# MEDICAID FRAUD AND ABUSE: ASSESSING STATE AND FEDERAL RESPONSES

## HEARING

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

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# MEDICAID FRAUD AND ABUSE: ASSESSING STATE AND FEDERAL RESPONSES

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**TUESDAY, NOVEMBER 9, 1999**

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
*Washington, DC.*

The subcommittee met, pursuant to notice, at 10:30 a.m., in room 2322, Rayburn House Office Building, Hon. Fred Upton (chairman) presiding.

Members present: Representatives Upton, Burr, Bilbray, Bryant and Green.

Staff present: Chuck Clapton, majority counsel; Amy Davidge, legislative clerk; and Chris Knauer, minority investigator.

Mr. UPTON. It must be 10:30. Good morning, everyone.

Today we're going to hold a hearing to look at fraud and abuse in the Medicaid program. Unlike the more publicized problem of Medicare fraud, less attention has been paid to fraud in the Medicaid program, which helps to pay for the health care costs of many of our poorest and oldest citizens.

I hope that by focusing greater attention on this problem, we can encourage State and Federal authorities to increase their efforts to reduce Medicaid fraud and abuse. The amounts of money being lost to Medicaid fraud are staggering. Using the more conservative estimate of 10 percent that has been previously suggested by the GAO, Medicaid may have lost as much as $17 billion to fraud and abuse during fiscal year 1998.

No one knows precisely how much fraud has actually cost the Medicaid program, however, although many experts believe the number may be far higher than the 10 percent estimate that I used.

As we will hear from our witnesses today, Medicaid fraud and abuse is a problem which appears to be growing worse. Just last week, the GAO released a report which had been requested by Senator Susan Collins from Maine. This report described how Medicaid and Medicare are increasingly being defrauded by organized criminal groups which are carrying out sophisticated and well-organized crimes and scams. Each of these frauds can cost the Medicaid program tens and even hundreds of thousands of dollars every month, maybe even millions. According to the report, many criminals now regard Medicaid cards as their own personal Visa or MasterCards which can be used to obtain money wherever and whenever they need it.

In order to assess how well States and the Federal Government are responding to the Medicaid fraud problems, we should heed the advice of Professor Malcolm Sparrow and count the zeros. Professor Sparrow, one of the foremost academic experts in the field of health care fraud, has described a process for comparing the total value of claims paid, estimated losses to Medicaid fraud and the amounts invested in program integrity efforts.

For example, Medicaid last year paid approximately $177 billion in claims and, using a conservative estimate, lost $17 billion to fraud and abuse. That's a 17 followed by 9 zeroes. Funding for Medicaid Fraud Control Units, which serve as the principal agent for investigating and prosecuting Medicaid fraud, was only $85 million—or 85 followed by 6 zeroes.

Even taking into account additional funding for other program integrity activities, Professor Sparrow estimated that the total amount invested to protect Medicaid from fraud and abuse is no more than a few hundred million dollars. This clearly reflects a severe underinvestment in program integrity amounts.

Nowhere are the effects of this underinvestment more pronounced than in the acquisition and use of computer tools to detect fraud and abuse. As anyone who has recently purchased a PC can tell you, technology is changing so rapidly that a computer bought only last year is now out of date, and one purchased 5 years ago is almost hopelessly antiquated. How then can we expect State Medicaid agencies, some of which are still using 10-year-old computer systems to process and review Medicaid claims, to have any hope of uncovering these new, highly complex fraud schemes?

In order to address these concerns, several technology vendors have developed new computer tools to assist State efforts to detect Medicaid fraud and abuse. The witnesses on the second panel today, including Jean McQuarrie from Medstat technologies from Michigan, are providing new and innovative ways for States to acquire the latest in technology systems to improve their anti-fraud efforts.

I look forward to hearing from these witnesses and seeing demonstrations of how these products can, in fact, improve anti-fraud efforts. In addition, I look forward to hearing from all of today's witnesses on what else can be done to control the Medicaid fraud problem. Whether it is through policy changes or through the continuing use of congressional oversight to identify problem areas, we in Congress do have an obligation to do our very best to protect this important program.

I yield to the gentleman from Texas, Mr. Green, for an opening statement.

Mr. GREEN. Thank you, Mr. Chairman. And thank you for scheduling this important hearing and bringing this to our attention.

As a member of the Health and Environment Subcommittee, I have attended several hearings on the issue of health care fraud. Traditionally, because of how these programs are financed, our primary focus has been reducing Medicare fraud, in fact, not only on this committee but in earlier service on the Government Operations Committee.

While HCFA has made significant improvements in reducing the amount of overpayments and mispayments to Medicare providers,

it's time for us to focus our attention to the Medicaid program. The fact that the amount of fraud in the Medicaid program is estimated to be at least 10 percent of all claims and as much as 30 percent tells us we have a lot of work to do.

If the conservative estimate of 10 percent is accurate, then it translates into approximately $17 billion in improper payments. As the overall percentage of fraud increases, it becomes clear that we may be misspending over $50 billion per year. This, incidentally, would be enough to pay for things such as a prescription drug benefit for seniors.

Unfortunately it's our responsibility to make sure that every appropriate action to reduce fraud at every level of the Medicaid program is implemented. But before we can do that, we have to first identify how much money is being wasted and what steps can be taken to reduce that fraud.

I look forward to the witnesses and the hearing we have today, Mr. Chairman, especially the GAO who is releasing a report today on this very issue; and I yield back my time.

Mr. UPTON. Thank you.

Mr. Burr, the vice chairman, for an opening statement.

Mr. BURR. Thank you, Mr. Chairman; and thank you for this hearing on Medicaid fraud and abuse. It's not the first, it won't be the last, and as I walked over I've got to admit I've got some great questions today. But the big question is. Will the answers be different than anything this committee has heard before? We always do a tremendous job of reiterating in 5 or 6 different ways that staff memo as to why we're holding this hearing.

I want to thank all the witnesses, Panel I and Panel II, for their willingness to come today, but I would also plead with you, tell us what the solution is. I'm tired of having IG reports that tell us that waste, fraud and abuse exists; and whether it's 5 percent or 10 percent or 30 percent, if it exists, it ought to be eliminated. Tell us what the problem is. Is the problem that we need to get the Federal Government out of the structure of the programs and let the States do it or get more involvement from the private sector as it relates to determining where the fraud and abuse is and identifying how to eliminate it?

We can all speculate as to what the problem is. But until those who are the closest to it can tell us how to eliminate it, we will continue to hold hearings that continue to discuss waste, fraud and abuse, a rip-off of the American taxpayers but, more importantly, money that is devoted to health care to individuals across this country that does not make it to them and does not make it to their coverage.

I agree with Mr. Green, there are many things we can do with this money if we can figure out how to make sure that it's accounted for and to make sure that the criminal element in there—I made comments when I came to Congress, Mr. Chairman, that there's one thing I will always be convinced of, coming from the private sector, that thieves are much smarter than bureaucrats.

It will always exist that they will outsmart every trap that we're able to create, but there will be an element always of waste, fraud and abuse and that our objective is to make sure it's as small as it can possibly be. I don't know that we can get there until we layer

back the complicated delivery systems that we have designed, and I look forward to our witnesses' comments on that.

And I yield back.

Mr. UPTON. Thank you.

Mr. Bryant.

Mr. BRYANT. Thank you, Mr. Chairman.

Let me immediately associate myself with the remarks of my colleague from North Carolina on this and just tell you that I have a long opening statement that I will give that I will submit for the record.

I will also add that, as a former United States attorney, we were one of the first offices—one of the first, there were several ahead of us—one of the first to open up a fraud and abuse section on health care. And what we found out immediately was that our Federal investigative agencies—and I'm not going to name the names, but you all know who they are—did not have that in those days as a priority. And, of course, they were out fighting drugs and white collar crime and bank robberies and all kinds of other things that are very important, but we found an amazing group of Statewide people who regulated the State medical industry, investigators there who, they cannot find prosecutors, local district attorneys to prosecute their cases. So we put together that team of Federal prosecutors primarily with State investigators and had some success there.

But I remember sort of what my friend from North Carolina said. I remember back in those days it was not that big of a push. But I think poignant to this hearing is the fact that we were finding criminals from other areas, we were getting out of the old areas of ripping off people and getting into the health care because it was so easy and so much money involved here, and I sense, after hearing some of the reports that we've had and some the statements that will be presented today, that that still is going on.

So I wish you could come in here and give us an easy answer. There is no easy answer. We know that. But if you can—as my colleague has said, if you can give us some ideas of what we can do, it may be this is just such a massive area that it cannot be controllable, but we have to do better. And we will never get to the end, but we have to do better.

And, again, thank all of you for coming in. I look forward to hearing from you and you answering our questions. Thank you.

Mr. UPTON. Thank you.

Mr. Bilbray.

Mr. BILBRAY. Mr. Chairman, I think my colleagues on both sides of the aisle have addressed this item for opening statements quite appropriately, and I would yield back with the request that we get to testimony. Thank you very much.

Mr. UPTON. Thank you.

I would just like to ask for unanimous consent that all members of the subcommittee may submit in full, in their entirety, any opening statements that they may have. And so moved.

[Additional statement submitted for the record follows:]

PREPARED STATEMENT OF HON. TOM BLILEY, CHAIRMAN, COMMITTEE ON COMMERCE

Let me begin by thanking Subcommittee Chairman Upton for holding this hearing today. By focusing public scrutiny on the issue of Medicaid fraud and abuse, we can hopefully raise the level of awareness about this troubling problem, and encourage the state and Federal agencies to redouble their efforts.

Health care fraud and abuse is an enormous problem in this country, with a cost that has been estimated by some experts to exceed $100 billion every year. In the Medicaid program alone, the cost of fraud and abuse may exceed $17 billion every year. While these numbers are shocking, they fail to convey the human impact of this sort of fraud. Our greatest concern should relate to how this type of fraud hurts our most vulnerable citizens, the poor, the elderly and the disabled, who all depend on Medicaid to provide their health care needs. Every dollar that Medicaid loses to fraud and abuse is a dollar that does not go to health care for these individuals. So, it is particularly troubling to me that Medicaid fraud is on the rise.

Too often, Medicaid anti-fraud efforts have been overshadowed by larger initiatives which focused on fraud and abuse affecting Medicare. The Committee on Commerce has sought to focus attention on the issue of Medicaid fraud through its recent oversight work. Committee staff have interviewed many of the agencies and individuals who serve on the front lines of current efforts to control Medicaid fraud, to learn what can be done to improve current efforts. A recent General Accounting Office report, prepared for Senator Susan Collins, detailed the growing sophistication of criminal organizations exploiting Medicaid and other government health care programs. Increasingly complex fraud schemes, each of which can cost State Medicaid programs hundreds of thousands of dollars every month are detailed. To further avoid detection, these groups often rapidly move from State to State. They also often quickly move the proceeds overseas, which makes it almost impossible for law enforcement to recover these monies, if and when the fraud is ever detected.

To combat this problem, the Medicaid program relies upon an array of State and Federal agencies. Unfortunately, these agencies are not set up to work in concert. Activities are often uncoordinated, and in many cases the agencies lack the resources to adequately address fraud.

We will hear today from current and former State officials who will describe how some Medicaid agencies are still relying on twenty year old computers to detect and track fraud and are operating on budgets that under fund Medicaid program integrity efforts.

If we are to make progress to protect Medicaid recipients from fraud and abuse, we must encourage the States to take the necessary steps to address these issues. At the Federal level, both the Health Care Financing Administration (HCFA) and the Office of Inspector General at the Department of Health and Human Services need to better coordinate their efforts.

The benefits from such efforts have already been demonstrated. In recent years, limited multi-state anti-fraud initiatives, coordinating the activities of a wide array of agencies responsible for combating health care fraud, have lead to finding almost $200 million in inappropriate payments. Such initiatives should serve as a model for future efforts to detect and prevent Medicaid fraud. We have the capability to combat this problem, and we have an obligation to the folks who use the Medicaid program to ensure that we are doing all that we can to stop fraud and abuse in this important program.

Mr. UPTON. With that, we will start with the testimony.

Ladies and gentlemen, we have a long tradition in this subcommittee, and you may know, of taking testimony under oath. Do any of you have objection to that?

We also allow for counsel both under committee rules and under House rules. Do you need counsel? And, if not, if you would all stand and raise your right hand.

[Witnesses sworn.]

Mr. UPTON. Thank you. Let me just introduce you for the audience, and we will proceed.

Ms. Leslie Aronovitz, the Director of the Chicago Field Office, GAO; Mr. Jack Hartwig, Deputy Inspector General for Inspections, Office of the Inspector General; John Krayniak, Director of the Medicaid Fraud Control Unit, Division of Criminal Justice for the State of New Jersey; Ms. Gwen Williams, from Montgomery, Ala-

bama; Mr. Marc Fecteau, Assistant Director, Department of Human Services, Bureau of Medical Services, for the State of Maine; and Ms. Penny Thompson, Director, Medicare Program Integrity Group, Health Care Financing Administration, HCFA, from Baltimore, accompanied by Ms. Rhonda Hall, the National Coordinator of Medicaid Fraud and Abuse.

Ladies and gentlemen, we thank you and welcome. We would like you to limit your remarks to 5 minutes. We've got this new timer up here instead of the kitchen timer that we've had for a year. So this is brand new. It will give you a little warm-up light, a yellow light, before your 5 minutes expires. Your testimony will be made part of the record in its entirety.

Ms. Aronovitz, we will begin with you. Thank you for coming this morning.

**TESTIMONY OF LESLIE G. ARONOVITZ, DIRECTOR, CHICAGO FIELD OFFICE, U.S. GENERAL ACCOUNTING OFFICE; JOHN E. HARTWIG, DEPUTY INSPECTOR GENERAL FOR INSPECTIONS, OFFICE OF THE INSPECTOR GENERAL HHS; JOHN KRAYNIAK, DIRECTOR, MEDICAID FRAUD CONTROL UNIT, DIVISION OF CRIMINAL JUSTICE, STATE OF NEW JERSEY; GWENDOLYN H. WILLIAMS, MONTGOMERY, ALABAMA; MARC P. FECTEAU, ASSISTANT DIRECTOR, DEPARTMENT OF HUMAN SERVICES, BUREAU OF MEDICAL SERVICES, STATE OF MAINE; AND PENNY THOMPSON, MEDICARE PROGRAM INTEGRITY GROUP, HEALTH CARE FINANCING ADMINISTRATION, ACCOMPANIED BY RHONDA HALL, NATIONAL COORDINATOR, MEDICAID FRAUD AND ABUSE**

Ms. ARONOVITZ. You're very welcome.

Mr. Chairman and members of the subcommittee, we are pleased to be here today to discuss ways to combat fraud and abuse in the Medicaid program. Federal and State expenditures total over $175 billion a year and pay for the health care of 40 million poor mothers, their children, and poor elderly, blind and disabled individuals. Neither the beneficiaries nor Federal and State taxpayers can afford to see these funds misspent.

We have just launched a study to better understand the scope and effectiveness of Medicaid program integrity efforts at the Federal and State levels and we will report on our results next spring.

Today my remarks will focus on a brief overview of the multiple players involved in addressing Medicaid fraud and the importance of Federal and State cooperation.

Medicaid fraud and abuse control entails a complex mix of characters and entities. For a composite view of this mix, I call your attention to the easel on your right. You can find a more detailed chart on page 4 of your written statement, and you should have a small copy of the chart with your materials.

As a practical matter, the front line of oversight and enforcement takes place in the States, so I will begin with the middle section of the chart first. The two key players at the State level are the State Medicaid agency and the Medicaid Fraud Control Unit, which—and I'm not making this up—as everyone in the enforcement business calls it, the MFCU. Each State has its own Medicaid agency, generally located in the State's Department of Health and

Welfare or Human Services. The State Medicaid agency not only pays claims and performs other administrative duties, but it also conducts program integrity activities.

State Medicaid agencies typically have a data analysis unit called a SURS, which stands for Surveillance and Utilization Review Subsystem. The SURS unit is dedicated to reviewing paid claims to identify suspect billing practices or other aberrations indicating potential wrongdoing. Separate from the State Medicaid agency, 47 States have MFCUs, again the Medicaid Fraud Control Unit, which are generally located in the State's Attorney General's Office. The MFCUs carry out investigations and in most States have the authority to prosecute.

This brings us to the local level, where the local district attorney can assist the State MFCU or prosecute in situations where MFCUs do not have prosectorial authority.

At the Federal level, you will notice that the two key departments are Health and Human Services, and Justice. Within HHS are the Health Care Financing Administration and the Office of Inspector General HCFA oversees the States' Medicaid agencies and the IG oversees the States' MFCUs. In the Justice Department, the key players are the U.S. Attorneys and the FBI.

Our previous work shows that various Federal, State and local agencies may have different or competing priorities in their efforts to investigate, prosecute and enforce compliance. This complicates Federal and State fraud control efforts and makes such orchestrated government stings as Operation Gold Pill and Operation Restore Trust, which are discussed in our written statement, remarkable examples of interagency coordination.

Our work in this area also shows that, in addition to coordinating the multiple players, investing in preventive strategies and dedicating adequate resources to fraud control, units are essential components of an effective program integrity strategy.

One issue we are pursuing in our study is the appropriate role for HCFA in working with the States. We recognize the difficulty in striking a balance between the stewardship of Federal Medicaid funds and the need for flexible approaches in dealing with 50-plus separate Medicaid programs. However, mindful of that balance, HCFA is in a position to explore in partnership with all of the States the appropriate level of commitment to preventing and detecting fraud and abuse. We think it's important because both have a fiduciary responsibility to administer Medicaid efficiently and effectively.

This concludes my prepared statement, and I will be happy to answer questions that you may have.

[The prepared statement of Leslie G. Aronovitz follows:]

PREPARED STATEMENT OF LESLIE G. ARONOVITZ, ASSOCIATE DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GAO

Mr. Chairman and Members of the Subcommittee: We are pleased to be here today as you discuss ways to combat fraud and abuse in the Medicaid program. Some 40 million Americans—not only poor mothers and children but also poor elderly, blind, and disabled individuals—depend on health care services made possible by the Medicaid program. With total expenditures of over $177 billion in fiscal year 1998, Medicaid is the third largest social program in the federal budget and represents a significant share of individual state budgets as well.

Fraud and abuse drains away vital program dollars and exploits taxpayers and vulnerable beneficiaries. As we recently reported, consumers and legitimate health care providers have been victimized by the fraud schemes of career criminals and organized criminal groups.[1] While the Department of Health and Human Services (HHS) and the Department of Justice have recently augmented their program integrity activities for Medicare, the Congress is concerned that a similar emphasis be placed on fraud and abuse control in Medicaid. We have just launched a study to better understand the scope and effectiveness of Medicaid program integrity efforts at the federal and state levels and will report our results next spring. Today, my remarks will focus on a brief overview of the problem, several key components of fraud control, and the importance of federal and state cooperation. My comments are based on observations gleaned from our prior work addressing both Medicaid and Medicare program integrity issues and from our ongoing Medicaid study.

In summary, our body of work on health care fraud and abuse indicates that programs the size and structure of Medicaid are inherently vulnerable to exploitation. Fraud schemes often cross state lines and enforcement jurisdictions, entailing a number of federal, state, and local agencies that may have different or competing priorities in their efforts to investigate, prosecute, and enforce compliance. Experience shows that coordinating the efforts of the multiple players, investing in preventive strategies, and dedicating adequate resources to fraud control units are essential components of an effective program integrity strategy. Finally, our work shows that the Health Care Financing Administration (HCFA), the agency in HHS responsible for administering Medicaid federally, is in a position to work in partnership with the states to ensure an appropriate level of commitment in states' efforts to control Medicaid fraud and abuse.

## BACKGROUND

Medicaid is a jointly funded federal-state health insurance program for eligible low-income and needy people. Although it is one federal program, as a practical matter, it consists of 56 separate programs (including the District of Columbia, Puerto Rico, and the U.S. territories). Within broad federal guidelines, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program. For fiscal year 1998, federal Medicaid expenditures were over $101 billion, with the states contributing about $76 billion. For each state, the federal share varies according to a statutory formula. The federal government picks up at least half the cost for medical services, and in nine states, it pays for more than 70 percent.

Medicaid fraud and abuse control entails a complex mix of actors and entities. At the federal level, HCFA and the HHS Office of Inspector General (OIG) have program oversight responsibilities. The Federal Bureau of Investigation (FBI) and the U.S. Attorneys in the Department of Justice are responsible for enforcement under certain conditions. However, front line oversight and enforcement reside primarily with the states. Each state administers its Medicaid program through a state Medicaid agency—variously situated in departments such as health, welfare, or human services. In addition to paying claims and performing other administrative duties, the state Medicaid agencies conduct program integrity activities. Many state Medicaid agencies have a "data mining" unit—a surveillance and utilization review subsystem (SURS) unit—dedicated to reviewing paid claims to identify suspect billing practices or other aberrations indicating potential wrongdoing. Separate from the state Medicaid agency, 47 states have Medicaid Fraud Control Units (MFCU), generally located in the state's attorney general's office, which carry out investigations and prosecutions. For a composite view of the multiple agencies involved in Medicaid fraud and abuse control, see table 1.

[1] *Health Care: Fraud Schemes Committed by Career Criminals and Organized Criminal Groups and Impact on Consumers and Legitimate Health Care Providers* (GAO/OSI-00-1R, Oct. 5, 1999).

1. Overview of Medicaid Fraud and Abuse Control Efforts

| Agency | Responsibility | Related activities |
|---|---|---|
| **Federal** | | |
| Department of Health and Human Services (HHS) | | |
| **Health Care Financing Administration (HCFA).** | Oversees state Medicaid agencies ..... | Among other activities, through its Medicaid Fraud and Abuse National Initiative, HCFA provides an ongoing forum and training for state officials on fraud control. |
| **Office of Inspector General (OIG).** | Oversees state Medicaid Fraud Control Units.<br>Investigates federal Medicaid fraud cases. | The OIG can sanction fraudulent providers by imposing exclusions and civil monetary penalties.<br>It refers investigative findings to DOJ. |
| Department of Justice (DOJ) | | |
| **U.S. Attorneys** ..... | Prosecute Medicaid fraud cases referred by FBI and HHS OIG. | The U.S. Attorneys also indict, negotiate settlements, and make recoveries. |
| **Federal Bureau of Investigation (FBI).** | Investigates federal fraud cases but cannot impose sanctions. | The FBI refers investigative findings to the U.S. Attorneys. |
| **State** | | |
| **State Medicaid agency** (located in such departments as health, human services, and welfare). | Administers state Medicaid program and oversees Medicaid program integrity activities. | The state Medicaid agency's activities may include conducting pre- and postpayment claims reviews and administering the provider enrollment process. |
| **Program integrity/surveillance and utilization review subsystem (SURS)[1] unit.** | Reviews claims data to detect and investigate aberrant payment patterns and conducts other types of integrity activities. | SURS units refer suspected fraud cases to the state's MFCU and noncriminal cases to the state Medicaid agency's collection unit. |
| **Medicaid Fraud Control Unit (MFCU)[2]** (generally in state Attorney General office). | Investigates and prosecutes cases involving fraudulent Medicaid activities.<br>Investigates and acts on complaints of abuse or neglect of patients in facilities receiving Medicaid funding. | The MFCU may refer cases that will not be prosecuted to the state Medicaid agency or other authority for administrative action. |
| **Local** | | |
| **District attorney** ..... | Prosecutes Medicaid fraud cases in states where MFCUs do not have prosecutorial authority. | |

[1] States vary in how their program integrity activities are organized and in what the units are called.
[2] Three states do not have MFCUs—Idaho, Nebraska, and North Dakota.

## FRAUD AND ABUSE ARE A PERSISTENT PROBLEM IN MEDICAID PROGRAM

The magnitude of fraud and abuse in the Medicaid program has not been quantified. Nevertheless, similar fraud and abuse schemes crop up in different states, and states have problems with fraud and abuse under both fee-for-service and managed care payment methods. Medicaid is vulnerable to fraud because of some intrinsic characteristics—such as its share of states' budgets and its vulnerable beneficiary population.

### *Several Types of Fraud and Abuse Are Common in Medicaid*

Common Medicaid fraud and abuse schemes generally fall into three broad groups: improper billing practices, misrepresentations of professional or service qualifications, and improper business practices.[2] Improper billing practices include "upcoding," in which the provider misrepresents treatment provided and bills for a more costly procedure; "ghost" or "phantom" billing, in which a provider bills for services never provided; and delivering more treatment than is either necessary or appropriate for the patient's diagnosis. Misrepresenting qualifications encompasses such offenses as submitting false credentials to obtain a Medicaid provider number and performing treatments outside the bounds of what is permitted by one's license. Among the improper business practices found in Medicaid are kickbacks for referring or otherwise steering patients to a particular provider or product such as pharmaceuticals; self-referrals, in which providers, for example, may order and request lab tests from companies they own or have a financial interest in; and antitrust violations, in which companies collude with each other or with providers to improperly

[2] Fraud involves a willful act to deceive for gain, whereas abuse typically involves actions that are inconsistent with acceptable business and medical practices.

influence payments or fees. Table 2 contains examples of fraud and abuse cases from the files of state MFCUs.

Table 2: Examples of Medicaid Fraud and Abuse

| Type of fraud | Example |
|---|---|
| Billing Fraud | A psychiatrist operated a "psychotherapy mill," in which parents were enticed to enroll their children in "free" enrichment programs such as after-school tutoring, field trips, and supervised recreation in exchange for their children's Medicaid numbers. Using these numbers, the psychiatrist billed Medicaid for psychotherapy services not provided. A psychologist he employed discovered the scam and negotiated a higher salary from him. The psychologist also set up her own copycat operation. State officials estimated that the two fraudulently obtained $421,000 from Medicaid. The defendants pleaded guilty, were ordered to pay fines and restitution, and received probation. **Source: Georgia State Health Care Fraud Control Unit.** |
| Business Practices Fraud | Two businessmen pleaded guilty to felony charges related to a complex scheme of submitting fraudulent nursing home cost reports to the state's Medicaid program. The scheme involved a nursing home chain and a shell corporation that the chain allegedly contracted with, enabling the owners to bill Medicaid for inflated expenses related to phony contracts with the nursing homes. Through a complex web of bank and investment accounts, the owners laundered payments. The scheme, which netted the owners nearly $10 million in excess Medicaid reimbursements, was discovered when a state auditor became suspicious of high payments to the shell company. One of the defendants received 50 months in prison and a $70,000 fine; the other, 36 months in prison and a $50,000 fine. Both received an additional 3 years of supervised release. As restitution, the pair agreed to pay about $6 million to the state Medicaid program and to forfeit of an additional $2-million-plus in assets. **Source: Georgia State Health Care Fraud Control Unit.** |
| Fraudulent Misrepresentation of Qualifications. | A woman, who had never attended, graduated, or received a degree from a nursing school, presented a false nursing license to several nursing homes that employed her. She also contracted with a county Board of Mental Retardation and Developmental Disabilities to provide nursing and counseling services. The misrepresentation was discovered when substandard care she provided led to complaints and a subsequent investigation. A state nursing board determined that the woman posed as a nurse for at least 5 years. She was charged with felony Medicaid fraud, felony forgery, and misdemeanor practice of unlicensed nursing. She pleaded guilty and was sentenced to 5 years' probation and was ordered to either pay some $3,850 in restitution or perform 84 days of community service. **Source: Ohio Attorney General's Health Care Fraud Section.** |

Fee-for-service providers do not have a monopoly on fraudulent and abusive health care practices. Under managed care, providers intending to exploit the program have adapted to new financial incentives. Whereas receiving a fee for each service enables providers to enhance revenues by ordering too many services, receiving a lump-sum payment in advance for each enrollee can encourage dishonest providers to enhance their profits by stinting on patient care. Consistent with this incentive are examples of Medicaid managed care fraud and abuse by prepaid health plans: avoiding expensive treatments, underfinancing plan operations, providing poor quality care, using deceptive marketing practices, and claiming phony enrollments. In a specific instance in Tennessee, a managed care plan used a homeless shelter as the address for nearly 4,500 fictitious enrollees—a scheme that was generating nearly $450,000 a month in fraud losses to Medicaid. The scheme came to light once the shelter tipped off the state Medicaid agency. Managed care plans can also engage in fraudulent business practices similar to those in fee-for-service health care—such as providing kickbacks for referrals or having unqualified personnel provide services.

Fraud and abuse schemes also cross jurisdictional and program boundaries, complicating the task of pursuing the perpetrators. In our October 1999 correspondence on health care fraud, we noted that criminal groups have created interstate health care fraud schemes and have used associates in foreign countries to transfer ill-gotten proceeds out of the United States. For example, a group with ties to a New Jersey scheme purchased a lab in Illinois and began bilking Medicaid and Medicare there. In another case, two individuals investigated for Medicaid fraud in south Florida were tied to three individuals in North Carolina who used a similar scheme

to falsely bill Medicare. Proceeds from this scam were laundered through associates in Mexico.

*Medicaid Is Vulnerable to Fraudulent and Abusive Practices*

Certain characteristics of the program make Medicaid an attractive target for exploitation, as follows:

- As a third-party payer, Medicaid pays for services provided by others and cannot, as a practical matter, police each claim for reimbursement submitted. In a state like New York, the very size of the program invites exploitation. In fiscal year 1998, New York's Medicaid program, covering roughly 2 million beneficiaries,[3] cost an estimated $27 billion. Medicaid consumes, on average, 20 percent of a state's budget.
- The impermanence of the population, owing to beneficiaries' changing eligibility status, makes the program a target for such schemes as billing for services provided to ineligible or deceased individuals.
- Because many states pay considerably less under Medicaid than providers' customary charges, Medicaid providers are often in short supply. Thus, program administrators are reluctant to impose controls that are perceived as burdensome for fear of discouraging provider participation.

## COORDINATION, PREVENTION, AND ADEQUATE RESOURCES ARE KEY FRAUD CONTROL ELEMENTS

Our prior health care program integrity work has shown that strong federal and state leadership is needed to ensure that three essential fraud control elements are in place. First, the multiple agencies involved must coordinate their efforts effectively. Second, HCFA and the states must focus on preventive strategies, since detection and prosecution efforts alone cannot stem program losses. Finally, state agencies need the administrative and technical tools and resources to accomplish their mission.

*Coordination Essential, but Difficult to Achieve*

Examples from our prior program integrity work underscore the importance of coordinating the efforts of multiple law enforcement and oversight agencies. One of our reports focused on Medicaid prescription drug diversion,[4] often referred to as "pill-mill" fraud, in which physicians, clinic owners, and pharmacists collude with willing beneficiaries by fraudulently prescribing and distributing prescription drugs. In some cases, pharmacists added medications to beneficiaries' orders and kept the extra for resale; clinics provided unneeded prescriptions to beneficiaries, who would trade them for merchandise; and providers gave beneficiaries prescriptions for drugs in exchange for their Medicaid number to bill for services not provided. We noted that a drug diversion case could typically involve five or more state, local, and federal agencies in its investigation, prosecution, and resolution. Network diversion schemes could involve third-party payers other than Medicaid, entrepreneurs, beneficiaries, middlemen, and physicians not enrolled in Medicaid. Handling such schemes could entail coordination between, for example, a MFCU in the state's department of law and other agencies with jurisdiction, such as an office of professional medical conduct in the state's department of health, an audit office in the state's department of social services, and an office of professional discipline in the state's department of education.

Two examples illustrate the payoff resulting from agency cooperation. One is the FBI's Operation Goldpill. Working with other federal agencies and with state MFCUs and regulators, approximately 1,000 FBI agents participated in the FBI's largest health care undercover operation at that time, involving 50 cities nationwide. This initiative reflected a new strategy focusing on multidefendant conspiracy indictments rather than single-defendant prosecutions. Through this effort, law enforcement agencies were able to charge 254 defendants; seize $10.8 million in assets, including 11 pharmacies; and levy $6.6 million in fines.

The second example—Operation Restore Trust (ORT)—represented a cornerstone in recent health care fraud coordination, which focused on Medicare and Medicaid fraud and abuse. ORT brought together the HHS OIG and other federal, state, and local agencies to target wrongdoing by home health, nursing home, and durable medical equipment providers, initially in five states. In its first 2 years of operation, ORT identified $188 million in inappropriate payments. Among the lessons learned was the importance of coordination among the various program and enforcement

[3] Our data on New York's beneficiary enrollment reflects calendar year 1998.

[4] *Medicaid Drug Diversion Fraud: Federal Leadership Needed to Reduce Program Vulnerabilities* (GAO/HRD-93-118, Aug. 2, 1993).

agencies involved at the federal, state, and local levels. For example, coordination between Medicare claims administration contractors and state licensing inspectors in the project states resulted in the decertification of many of the targeted home health agencies and the recovery of substantial sums in inappropriate payments. Through the Medicare contractors' efforts to train state inspectors on specific billing and beneficiary coverage issues, the inspectors were able to provide the contractors information they might not otherwise have been able to obtain on beneficiaries who were not eligible or home health agencies that billed for services not provided. Through this mutual exchange of information, contractors were able to identify an array of billing abuses costing the government millions of dollars.

As obvious as the benefits are from interagency coordination, several barriers exist that discourage such cooperative efforts. Among these are the following:

- *Labor-intensity of building a case with uncertain outcome.* The level of resources and interagency coordination required for case development can stall the pursuit of a case at many junctures and delay the resolution of a case for many years. The pursuit of fraud often begins with the state Medicaid agency, which, to refer the case to a MFCU, must typically prepare careful documentation through data analyses, claims audits, interviews with patients, and medical record reviews. The MFCU may reject cases because of its backlog, insufficient evidence, or estimated dollar losses below a certain threshold. At the time of our drug diversion study, one state's MFCU typically rejected more than 90 percent of the Medicaid agency's fraud referrals because of staffing constraints. For cases accepted, MFCU investigations can involve, among other things, additional interviews or analyses of medical records and subpoena of financial records. If the case enters federal jurisdiction, the MFCU may forward the case to a U.S. Attorney. If the case is prosecuted and convictions are obtained, further work also may be necessary to establish administrative sanctions and recover overpayments.
- *Timing of actions to maximize administrative as well as criminal sanctions.* In our drug diversion study, we reported that the state agencies and MFCUs made little effort to time audits and criminal investigations so that civil recoveries could be made without compromising criminal prosecution. When poor communication exists between a MFCU and the state Medicaid agency, the state agency may be delayed in taking civil action before the statute of limitations has expired. In such cases, the agency may have to forgo the opportunity to assess monetary penalties or obtain recoveries that can restore financial losses to the Medicaid program.
- *Competing productivity goals between agencies.* One state's MFCU officials told us that a state Medicaid agency's SURS unit, for example, may be reluctant to classify provider overpayment cases as fraud. Fraud cases must generally be referred to the state MFCU. Cases classified as overpayments generally remain the within the SURS' jurisdiction, and recoveries are credited to the SURS' performance results.
- *Federal payback rules.* Federal law creates a fiscal incentive for states to avoid finding fraud.[5] The law requires that the state pay back the federal share of these overpayments within 60 days of discovery, regardless of whether the state has recouped its losses.[6]

We are currently reviewing states' efforts to enhance coordination in our ongoing study for the Committee. In Georgia, the MFCU has established working teams consisting of members from three state agencies—prosecutors from the Attorney General's office, investigators from the Georgia Bureau of Investigation, and auditors from the Department of Audits.

*Prevention Is Key to Avoiding Program Losses*

Preventive strategies designed to stop improper activity before Medicaid incurs losses is another essential control. Our observations on coordination difficulties demonstrate that efforts to detect and prosecute wrongdoing are important but are typically expensive and labor-intensive, sometimes with little financial recovery to show for the effort. Consistent with this view is HCFA's philosophy "to pay it right" instead of paying and chasing.

Preventive strategies can be embedded in the design of provider enrollment procedures, payment methods, coverage policies, and beneficiary eligibility verification. As we concluded from previous work, states' emphasis on developing preventive

[5] 42 U.S.C. 1396b(d)(2)(C).

[6] While this requirement may be appropriate under ordinary circumstances so that states are encouraged to seek recovery, it may not be appropriate in criminal cases in which recovery efforts could damage the investigation by alerting the suspect.

measures were well-placed because efforts to recover losses were often unsuccessful. In our ongoing study, we will examine states' approaches to fraud control prevention. One example—provider enrollment controls in the Medicare program—illustrates how such approaches help avert fraud.

- Until recently, when new requirements were established, Medicare procedures for certifying home health agencies were seriously flawed. For example, in a 1997 report,[7] we noted that becoming a Medicare- certified home health agency had been too easy, particularly in light of the number of problem agencies that had been identified in past years. There had been little screening of those seeking Medicare certification. For example, Medicare certified an agency owned by an individual with no home health experience who turned out to be a convicted drug felon and who later pleaded guilty with an associate to having defrauded Medicare of over $2.5 million. Rarely did new home health agencies fail the program's certification requirements. HCFA has since developed procedures to better scrutinize the qualifications and background of home health agency applicants.

*Adequate Resources Include Qualified Staff and Modern Technology*

An investment in adequate resources, consisting of qualified staff and modern payment safeguard technology, is a third element essential to effective Medicaid fraud and abuse control. Over time, health care fraud schemes have become increasingly complex, frequently involving networks of people, sophisticated computer techniques, and multiple geographic locations. In a 1994 Medicare report,[8] we focused on the results of a HCFA demonstration examining the effect of additional program safeguard funding. We found that the "demonstration" contractors had achieved higher medical review savings than the control group contractors because they committed more resources to improving their analytic tools and hiring qualified technical staff.

In recent interviews, officials in several states have expressed concerns that the lack of effective data systems has hampered their efforts to identify fraud. For example, one state official said that the state's Medicaid automated detection system is 15 years old and not well designed for the types of analysis needed today. Another official noted that the state lacked a system to perform electronic prepayment screening of claims, a tool that we have reported on in Medicare reports as a fundamental payment safeguard. Reflecting these concerns, a MFCU official stated that service data, staff capable of mining them, and state-of-the-art detection software are important tools for fraud control. Our ongoing study will examine the extent of states' capacity to identify fraud or abuse.

## HCFA'S ROLE IN MEDICAID FRAUD CONTROL

In recent years, HCFA has taken steps to improve its program integrity efforts in both Medicare and Medicaid. For Medicaid in particular, HCFA's role to date has been largely to facilitate training and information-sharing efforts for the states.

In 1997, HCFA established the Medicaid fraud and abuse national initiative designed to bring different components among and within states together at meetings and to provide training, share information, and address common concerns. As part of the initiative, individual committees have been created to work on specific problems and solutions. For example, a state legislation committee developed a database on a Web site that all states can access that catalogues states' program integrity legislation. This serves states seeking models for anti-fraud-and-abuse legislation and contacts for further information. A federal legislation committee has developed proposals to increase state effectiveness that have been added to HHS' legislative proposals. HCFA has also formed and funded a technical advisory group that meets regularly to discuss Medicaid program integrity issues.

Despite HCFA's positive efforts to facilitate states' activities, we are concerned about the agency's efforts to ensure that all states have effective program integrity strategies. In our June 1999 testimony on Medicaid payments for school-based services, we raised concerns about HCFA's role as steward of Medicaid funds. We noted that the agency's regional offices, lacking specific guidance, were inconsistent in their determinations of whether a given state's practices for claiming administrative costs were appropriate. Practices that HCFA had allowed in one state had not been allowed in others, resulting in confusion. It also created an environment in which

[7] *Medicare Home Health Agencies: Certification Process Ineffective in Excluding Problem Agencies* (GAO/HEHS-98-29, Dec. 16, 1997).

[8] *Medicare: Greater Investment in Claims Review Would Save Millions* (GAO/HEHS-94-35, Mar. 2, 1994).

school systems "pushed the envelope" into the realm of questionable billing practices.

From this particular work we made observations that apply to Medicaid fraud and abuse control in general. First, striking a balance between the stewardship of Medicaid and the need for flexible approaches in dealing with 50-plus Medicaid programs is difficult. However, mindful of that balance, HCFA is in a position to explore, in partnership with states, the appropriate level of commitment to preventing and detecting fraud and abuse. We think this is important because both have a fiduciary responsibility to administer Medicaid efficiently and effectively.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or the Subcommittee Members may have.

GAO CONTACT AND ACKNOWLEDGMENTS

For future contacts regarding this testimony, please call Sheila K. Avruch, Assistant Director, on (202) 512-7277. Key contributors to this testimony include Barrett W. Bader, Bonnie L. Brown, Hannah F. Fein, and Robert L. Lappi.

RELATED GAO PRODUCTS

*Financial Management: Increased Attention Needed to Prevent Billions in Improper Payments* (GAO/AIMD-00-10, Oct. 29, 1999).

*Health Care: Fraud Schemes Committed by Career Criminals and Organized Criminal Groups and Impact on Consumers and Legitimate Health Care Providers* (GAO/OSI-00-1R, Oct. 5, 1999).

*Medicaid: Questionable Practices Boost Federal Payments for School-Based Services* (GAO/T-HEHS-99-148, June 17, 1999).

*Fraud, Waste, and Abuse: The Cost of Mismanagement* (GAO/AIMD-98- 265R, Sept. 14, 1998).

*Nursing Homes: Too Early to Assess New Efforts to Control Fraud and Abuse* (GAO/T-HEHS-97-114, Apr. 16, 1997).

*Medicaid Fraud and Abuse: Stronger Action Needed to Remove Excluded Providers From Federal Health Programs* (GAO/HEHS-97-63, Mar. 31, 1997).

*Fraud and Abuse: Providers Excluded From Medicaid Continue to Participate in Federal Health Programs* (GAO/T-HEHS-96-205, Sept. 5, 1996).

*Medicare and Medicaid: Opportunities to Save Program Dollars by Reducing Fraud and Abuse* (GAO/T-HEHS-95-110, Mar. 22, 1995).

*Prescription Drugs: Automated Prospective Review Systems Offer Significant Potential Benefits for Medicaid* (GAO/AIMD-94-130, Aug. 5, 1994).

*Medicaid: A Program Highly Vulnerable to Fraud* (GAO/T-HEHS-94-106, Feb. 25, 1994).

*Medicaid Drug Fraud: Federal Leadership Needed to Reduce Program Vulnerabilities* (GAO/HRD-93-118, Aug. 2, 1993).

Mr. UPTON. Thank you very much.

Mr. Hartwig.

## TESTIMONY OF JOHN E. HARTWIG

Mr. HARTWIG. Good morning, and thank you for the opportunity to testify on the subject of Medicaid fraud and abuse and what is being done to address it.

While the vast majority of health care providers are honest, all large health care programs are vulnerable to exploitation, and Medicaid is no exception. Over the years, we have seen abuses in many forms.

The responsibility for detecting, investigating and prosecuting fraud and abuse in the Medicaid program is a shared responsibility between the State and Federal Governments. Each State is required to have a program integrity unit dedicated to detecting and investigating suspected cases of Medicaid fraud; and, as you have just heard, most States fulfill this requirement by establishing Medicaid Fraud Control Units.

The Office of Inspector General has oversight responsibilities for the fraud control unit, and those responsibilities include the initial certification and the yearly recertification of the Medicaid Fraud Control Units. We, the Medicaid Fraud Control Units and other law enforcement agencies work together to coordinate our anti-fraud efforts, and these partnerships have greatly enhanced our ability to carry out our mission.

Ten years ago, the OIG helped establish the National Health Care anti-fraud Association, representing both governmental and private third-party payers and law enforcement agencies, to coordinate government and private health care fraud enforcement activities. More recently, a National Health Care Fraud Task Force has been established to better coordinate State and local and Federal health care enforcement operations. In addition, the OIG and the Medicaid Fraud Control Units have joined together with other Federal and State law enforcement agencies to organize local health care fraud task forces throughout the country.

We have worked together on joint training exercises. As an example, the Office of Inspector General has sponsored a program to provide a 5-day session to Medicaid Fraud Control Unit investigators, and that program was held at the Federal law enforcement training center in Glynco, Georgia.

The Office of Inspector General has also sponsored training sessions regarding Federal grant regulations for the Medicaid Fraud Control Unit employees and other State administrative and financial staff.

I would also like to highlight an OIG cooperative effort with State Medicaid audit partners. Five years ago, we began an initiative to work more closely with State auditors in reviewing the Medicaid program. The partnership plan was created as an effort to provide broader coverage of the Medicaid program by partnering with State auditors, State Medicaid agencies and State internal audit groups. Sixteen State auditor reports have been issued under this partnership with a financial impact of $163 million.

The audit partnerships provide broader coverage of the Medicaid program and provide a more effective and efficient use of scarce audit resources by both the Federal and State audit sectors. We plan additional audit partnerships with the States to strengthen that capability.

In our oversight role, we are in the process of conducting a study that will assess the Medicaid program safeguards used in a sample of States and will provide information on States developing provider enrollment safeguards to assess keeping bad providers out of the program. We will also look at prepayment and claims processing and postpayment review at the States.

I appreciate the opportunity to come before you today to review the fight against fraud and abuse in the Medicaid program. I thank you and the committee for highlighting this important issue and allowing us to share with you our observations.

[The prepared statement of John E. Hartwig follows:]

PREPARED STATEMENT OF JOHN E. HARTWIG, DEPUTY INSPECTOR FOR INVESTIGATIONS, HHS OFFICE OF INSPECTOR GENERAL

Good Morning, I am John E. Hartwig, Deputy Inspector General for Investigations in the Office of Inspector General. Thank you for the opportunity to testify on the subject of Medicaid fraud and abuse and what is being done to address it. While the vast majority of health care providers are honest, all large health care programs are vulnerable to exploitation, and Medicaid is no exception. Over the years, we have seen abuses take many forms. Fraud, waste and abuse continue today, depriving taxpayers and consumers of the value of their contributions. Our sense, however, is that the States are steadily becoming more effective in limiting abuses through continuous improvements in their systems and processes.

With my time today, I will review some of the challenges that the States face in guarding the fiscal soundness of their Medicaid programs and share with you some recent examples of fraud perpetrated against the program. I want to describe how the States are partnering with our office, the Health Care Financing Administration and other Federal and State law enforcement offices to leverage their effectiveness. Finally, I want to describe some of the areas we have observed that provide opportunities for continued improvement.

## BACKGROUND

*The Office of Inspector General*

The Office of Inspector General (OIG) was created in 1976 and is statutorily charged with protecting the integrity of Departmental programs, as well as promoting their economy, efficiency and effectiveness. The OIG meets this statutory mandate through a comprehensive program of audits, program evaluations, and investigations designed to improve the management of the Department and to protect its programs and beneficiaries from fraud, waste and abuse. Our role is to detect and prevent fraud and abuse, and to ensure that beneficiaries receive high quality, necessary services, at appropriate payment levels.

*Medicaid Program*

The Health Care Financing Administration (HCFA) administers the Medicaid program. Authorized under Title XIX of the Social Security Act, Medicaid is a means-tested health care entitlement program financed by States and the Federal Government—approximately 43 percent from the States and 57 percent from the Federal Government in FY 1998. To date, all 50 States, the District of Columbia, and the five territories have elected to establish Medicaid programs.

Within the broad national guidelines that the Federal Government provides, each of the States establishes its own eligibility criteria. While there are specific Medicaid requirements, States have considerable flexibility in structuring their Medicaid programs, including provider payment rates, certification standards and development of alternative health care delivery programs. States are required to provide a core of mandatory Medicaid services to all eligible recipients. In addition, States have restructured eligibility coverage through "program" and "research and demonstration" waivers. These waivers allow States some flexibility to reform health care by expanding coverage, to create alternatives, and to allow beneficiaries to select their own Medicaid providers.

## FRAUD INVESTIGATIONS

The responsibility for detecting, investigating and prosecuting fraud and abuse in the Medicaid program is shared between the Federal and State Governments. Each State is required to have a program integrity unit dedicated to detecting and investigating suspected cases of Medicaid fraud. Most States fulfill this requirement by establishing a Medicaid Fraud Control Unit (MFCU). Each Medicaid State agency also has a Medicaid Management Information System. A subpart of this data system is the Surveillance and Utilization Review Subsystems Units (SURS). The SURS units are charged with ferreting out fraud by conducting preliminary reviews of providers and beneficiaries with aberrant claims or billing patterns that possibly indicate criminal fraud. When potential fraud cases are detected, the SURS refer the cases to the MFCUs. Regulations require the Medicaid State agencies and the MFCUs to enter into a Memorandum of Understanding in which the agencies agree to refer all cases of suspected provider fraud to the units.

*Medicaid Fraud Control Units*

In 1977, Congress enacted Public Law 95-142 which authorized Federal matching funds for States to voluntarily establish a Medicaid Fraud Control Unit. The Omnibus Budget Reconciliation Act of 1993 required the establishment of MFCUs unless a waiver is requested from the Secretary of the Department of Health and Human Services (HHS). These fraud units are part of the State Attorney General's office or other State agency that is separate and distinct from the Medicaid State agency. The purpose of the MFCUs is to investigate and prosecute Medicaid provider fraud, patient abuse and fraud in administration of the program.

The MFCUs are integrated law enforcement units composed of investigators, attorneys, auditors and analysts. At present, 47 States have fraud control units established and operating, while three States (Nebraska, North Dakota and Idaho) have received waivers from the Secretary. These waivers relieve these three States from the requirement to establish a Medicaid fraud control unit in the manner specified by the current Federal regulations.

The MFCUs investigate and prosecute allegations of Medicaid fraud and patient abuse or neglect. Specifically, they:

- Investigate and prosecute suspected cases of Medicaid fraud in connection with any aspect of the provision of medical assistance.
- Review and investigate complaints of abuse and neglect of patients in health care facilities that received payment under the State plan.
- Investigate suspected cases of fraud that occur within the Medicaid State agency.
- Provide for the collection, or referral for collection to the single State Medicaid agency, of overpayments that are made by health care facilities.
- Safeguard the privacy rights of all individuals and provide safeguards to prevent the misuse of information under the unit's control.
- Submit an annual report to the Secretary of HHS detailing the accomplishments and activities of the unit.

Where State law permits, fraud control units both investigate and prosecute cases statewide. In eight of the 47 States, the units do not prosecute their own cases but instead refer them to a Federal, State or County prosecutor. Cases are generated by the units themselves and also come from a variety of sources including the Office of Inspector General, the Medicaid agency (including the Surveillance and Utilization Review Subsystem units), other Federal and State agencies (such as Survey and Certification Units) and the media. In States with fraud control units, the Medicaid agency agrees to report all suspected cases of provider fraud to the unit. To ensure that Medicaid overpayments identified by the units through their investigations are recovered, the units are required to either undertake administrative recovery actions or have procedures to refer them for collection to other appropriate State agencies.

Although originally managed within HCFA, the oversight responsibilities for the fraud control units were transferred to the Office of Inspector General in 1979 since the Units' activities were determined to be more closely related to the OIG investigative function. Federal funds for the Medicaid fraud control program are included in the Health Care Financing Administration appropriation. The program reimburses the States for the cost of operating a unit at a rate of 90 percent for the first three years and 75 percent thereafter. Currently, all 47 MFCUs are receiving the 75 percent rate.

*Medicaid Fraud Control Unit Accomplishments*

Since the inception of the Medicaid fraud control program, the units have recovered hundreds of millions of program dollars. The following chart represents recoveries to the Medicaid program for the past five fiscal years for which data are available:

| YEAR | Federal Funding Allocated by HCFA | Actual Federal Expenditure | Federal/State Recoveries |
|---|---|---|---|
| 1998 | $87,000,000 | $85,793,887 | $83,625,633 |
| 1997 | $82,000,000 | $80,557,146 | $147,642,299 |
| 1996 | $79,000,000 | $77,453,688 | $57,347,248 |
| 1995 | $76,000,000 | $73,258,421 | $88,560,361 |
| 1994 | $65,600,000 | $64,573,926 | $42,780,015 |

It should be noted that there are areas of MFCU activity, such as patient abuse cases, that do not generate a monetary return, but are part of the overall effort to provide quality care and to hold the health care community accountable for the Federal and State dollars spent. In FY 1998, patient abuse cases accounted for over 30 percent of the 6,839 cases investigated by the 47 units.

Some types of fraudulent schemes currently under investigation by the MFCUs involve:

- *Billing for Services Not Provided.* This is one of the most common types of fraud. Examples include a provider who bills Medicaid for a treatment or procedure that was not actually performed, such as blood tests when no samples were drawn or x-rays that were not taken.
- *False Cost Reports.* A nursing home owner or hospital administrator may intentionally include inappropriate expenses not related to patient care on costs reports submitted to Medicaid.
- *Illegal Remunerations.* A provider (i.e., nursing home operator) may conspire with another health care provider (i.e., physician, ambulance company) to share a certain portion of the monetary reimbursement the health care provider receives (kickbacks) for services rendered to patients. Kickbacks include not only cash, but vacation trips, automobiles or other items. The practice results in un-

necessary tests and services being performed for the purpose of generating additional income to both the referring source and the provider of the service.

*Medicaid Fraud Control Units Case Examples*

Some recent cases investigated by the MFCUs include the following:

- A radiologist collected $1.7 million from Medicaid over a 26-month period by engaging in improper billing practices. Two-thirds of the services went to pay kickbacks to the clinic operators who supplied him a staggering total of 24,000 unnecessary, duplicate or phony tests to "review." Most of these tests, provided by representatives of local clinics, were of the same people, but they had been given different names and Medicaid identification numbers. The radiologist was convicted of grand larceny and sent to prison.
- In New Jersey, the owner of two medical clinics was indicted in 1997 for bilking Medicaid of more than $6 million. He claimed to have performed colonoscopies and other expensive procedures, even though he had no equipment for doing them.
- Two Atlanta businessmen pled guilty to felony charges for submitting fraudulent nursing home cost reports to the Georgia Medicaid program. The businessmen operated a "shell corporation" established primarily for creating inflated contracts with nursing homes. The nursing homes received an artificially inflated Medicaid per diem reimbursement rate. Between 1991 and 1996, the businessmen obtained nearly $10 million in excess Medicaid reimbursements. A State auditor uncovered the scheme in 1996 when he performed a routine audit and became suspicious of the high payments. The businessmen were indicted and were found guilty on eight counts of false documents. They were sentenced to 50 months in prison, required to pay restitution of approximately $6 million to the Medicaid program and to forfeit an additional $2.1 million in assets.
- A Maryland woman was convicted of felony theft for defrauding more than $19,000 from mentally disabled adults during a 6-month period in 1996. The woman stole social security checks from them and drained the savings accounts of disabled adults who were in her care. In one case, money was withdrawn from an existing account but never deposited into the patient's other account. Similarly, this woman stole from at least three other Medicaid recipients, depleting their accounts to the extent that they were unable to pay their rental expenses and were deprived of clothes and other essentials. She was sentenced to home detention and ordered to repay the victims.

*OIG Oversight of MFCUs*

The OIG has responsibility for oversight of the funding and operating standards of the 47 MFCUs, including coordinating part of their investigative training. During FY 1998, we provided oversight and administered approximately $85.8 million in funds granted by HCFA to the MFCUs to facilitate their mission. In FY 1999, HCFA's funding allocation amounted to $92.2 million. For FY 2000, $97.7 million has been allocated.

The OIG's oversight duties include the initial certification and yearly recertification of the MFCUs. Regulations require the MFCUs to submit an application to the OIG with an annual report and a budget request. The MFCU application, annual report, budget and quarterly statistical reports are reviewed by the OIG to determine if the MFCUs are in conformance with standards issued by the OIG. The OIG also reviews questionnaire responses from the Medicaid Agency and OIG Field Offices. On-site inspections and reviews of the MFCUs are conducted by the OIG on an as needed basis. The OIG maintains ongoing communication with individual State units and the National Association of Medicaid Fraud Control Units related to the interpretation of program regulations and other policy issues.

## FEDERAL AND STATE PARTNERSHIPS

The OIG has aggressively sought new and innovative ways to stretch our resources and thus maximize the effectiveness of our anti-fraud efforts. Over the years, we have forged new and stronger links with other Federal agencies, State governments and the private sector. A major component of the Health Insurance Portability and Accountability Act of 1996 was the establishment of a program to coordinate health care anti-fraud efforts. The OIG, MFCUs, and other law enforcement agencies work together to coordinate anti-fraud efforts. These partnerships have greatly enhanced our ability to carry out our mission.

Ten years ago, the OIG helped establish the National Health Care Anti-Fraud Association, representing both governmental and private third party payers and law enforcement agencies, to coordinate governmental and private health care fraud enforcement activities. Over the years, this governmental/private partnership group

has been extremely successful in fostering our collaborative efforts. More recently, the OIG has established with the Department of Justice and other enforcement agencies an Executive Level Working Group to focus on health care fraud. In addition, the OIG and MFCUs have joined with other State and Federal law enforcement agencies to organize health care fraud task forces throughout the country.

We have taken steps to develop partnerships and build a team to combat health care fraud and abuse. Listed below are examples of cases involving both the OIG and MFCUs:

- In Florida, a hospital health care corporation agreed to pay the Government $469,000 to resolve its liability under the False Claims Act and entered into a corporate integrity agreement with OIG. This agreement settles allegations concerning Medicaid claims submitted by one of its component facilities between 1995 and 1997. The claims at issue were submitted to the Florida Medicaid program, by one of the corporation's hospitals, for services rendered to patients in the adolescent psychiatric unit. Allegedly, the hospital billed for services not rendered or not provided in accordance with Medicaid requirements; and, the defendants failed to adequately document the length and nature of the services provided.
- A psychologist in Georgia is serving a 2-year prison sentence for defrauding the Medicaid program of approximately $209,000. The psychologist submitted false billings to Medicaid for services that were not medically necessary and services in excess of the number actually provided. In addition to imprisonment, the doctor was ordered to pay restitution in the amount of $209,000 and was excluded from the program for 15 years.
- An alcoholism clinic in New York was excluded for a period of 10 years for felony larceny. The two owner/operators of the clinic were involved in a scheme to defraud Medicaid, which lasted over five years. They submitted false claims that resulted in overpayments totaling approximately $113,000. Both owners were ordered to pay restitution in the aforementioned amount and were each excluded for 10 years.
- The OIG excluded a dentist because he was required to surrender his license to practice dentistry in California while a formal disciplinary hearing regarding his professional competency was taking place. After surrendering his license and being excluded from the Medicaid program by the OIG, the dentist moved to Oregon. While in Oregon, he applied for a license to practice dentistry with the appropriate licensing board and then for a provider number to bill Oregon's Medicaid program. In researching the dentist's current practices, the OIG determined that he had not been truthful about his exclusion status and that the Medicaid agency had an investigation in progress regarding his current billing practices. The dentist was subsequently convicted of Medicaid fraud and falsifying business records. He has been excluded again for an additional 10 years.

*Federal and State Audit Partnerships*

Other cooperative efforts include State Medicaid Audit Partnerships. Five years ago, we began an initiative to work more closely with State auditors in reviewing the Medicaid program. The Partnership Plan was created as an effort to provide broader coverage of the Medicaid program by partnering with State auditors, 11 State Medicaid agencies and two State internal audit groups. Sixteen State auditor reports have been issued with a financial impact of $163 million.

As health care fraud has become increasingly complex, we have found a greater need to coordinate with other law enforcement entities, as well as others, with a vested interest in fighting fraud and abuse. For example, our auditors partner with State auditors, other State groups including departmental internal auditors, departmental inspectors general, Medicaid agencies, and the Health Care Financing Administration's financial managers, to conduct joint reviews. The level of involvement of each partner is flexible and can vary depending upon specific situations and available resources.

The goal of our Federal and State partnership is not just to identify and recommend recovery of unallowable costs from State agencies. Rather, it is designed to focus on issues that will result in program improvements and reduce the cost of providing necessary services to Medicaid recipients. The Plan provides broader coverage of the Medicaid program and provides a more effective and efficient use of scarce audit resources by both the Federal and State audit sectors.

Since its inception in 1994, active partnerships have been developed in 22 States on such diverse issues as:

- Program issues related to Medicaid outpatient prescription drugs.
- Unbundling of clinical laboratory services.
- Outpatient non-physician services already included as an inpatient charge.

- Excessive costs related to hospital transfers.
- Excessive payments for durable medical equipment.
- Acquisition costs for Medicaid drugs.
- Program issues related to managed care.

Joint projects have also identified areas where improvements in program operations could be achieved, unallowable program expenditures could be recovered and future cost savings could be recognized.

*Clinical Laboratory Services.* One Partnership Project was undertaken to review Medicaid payments for clinical laboratory services. The objective of this review was to determine the adequacy of State agency procedures and controls over the payment of Medicaid claims for clinical laboratory services. Audits in 22 States examined pricing of lab tests and system edits and controls to detect and prevent duplicate payments and identified $33.9 million in Federal and State overpayments. The review also found that State Medicaid agencies did not have adequate controls to ensure that the Medicaid program did not pay more than Medicare would have paid for the same clinical laboratory tests.

*Dual Eligibles.* A unique example of OIG auditors, State Auditors, and Medicaid Fraud Control Units working together is an ongoing managed care initiative involving dual eligible Medicare/Medicaid beneficiaries. The objective of this review is to determine the extent of inappropriate Medicaid fee-for-service payments made on behalf of dually eligible beneficiaries while enrolled in a Medicare risk HMO. The review began with State Auditor work conducted in two States, Texas and Florida. The Texas State Auditors found that the State Medicaid claims on behalf of beneficiaries for prescription drug services should have been covered by the Medicare HMO. The Florida State Auditor's Office found that the Medicaid fee-for-service program improperly paid for medical services and drugs that should have been provided by the Medicare HMOs. The questioned payments amounted to over $15.8 million in Calendar Year 1996. As a result of the findings for 1996, the review was referred to the Florida Medicaid Fraud Control Unit which is continuing the review for 1994, 1995, 1997 and 1998.

## OPPORTUNITIES FOR CONTINUED IMPROVEMENT

I want to describe some recent and continuing activities that relate to improving anti-fraud and abuse efforts in the Medicaid program.

*Training*

The OIG sponsored a program to provide five-day training sessions for MFCU investigators at the Federal Law Enforcement Training Center (FLETC) in Glynco, Geogia. The training is administered by the Inspector General Academy in cooperation with the National Association of Medicaid Fraud Control Units and is intended to improve the effectiveness of the MFCUs in investigating and prosecuting Medicaid provider fraud and patient abuse and neglect.

The Office of Investigations also sponsors and coordinates training conferences regarding the Federal grant regulations for MFCU employees and other State administrative and financial staff. Additional training for MFCU investigators is available through the Health Care Fraud Investigations Training Program provided at the FLETC. The OIG, in cooperation with the Financial Fraud Institute at the FLETC, developed this two week training program. Course topics include health care fraud schemes, interviewing techniques, evidence gathering, case preparation and financial investigative techniques.

*Increased Auditing Partnerships*

Additional Federal and State partnerships will be developed with the States to strengthen the capability to detect, prosecute and punish fraudulent or abusive reimbursement activities. Potential audits and developing issue areas include:

- Medicaid denials of inpatient acute hospital stays.
- Physician clinical billing practices.
- Medical equipment, supplies, and related items.
- Medicaid prescription drugs—average wholesale price.
- Medicaid prescription drugs—dispensing fees.
- Hospice care—eligibility.
- Home health care—eligibility.
- Managed Care—payment of enhanced rates.
- Multi-state audit of long-term care to include licensing, inspections, violations, and reimbursement systems.
- Mental health services.

*Surveillance and Utilization Review Subsystem (SURS)*

In 1972, Congress enacted Public Law 92-603 that provided funding to States to foster development and implementation of the Medicaid Management Information System (MMIS). One of the subcomponents of the MMIS is the Surveillance and Utilization Review Subsystem (SURS). These units were designed to serve as major contacts and analysis points for detection and referral of potential fraud and provider abuse cases to assigned components within the States that pursue investigation of alleged criminal fraud within the Medicaid Program, usually the Medicaid Fraud Control Units.

As part of the Medicaid Management Information System, the SURS applies automated post-payment screens to Medicaid claims adjudication to identify aberrant billing patterns that may indicate fraud or provider abuse. The SURS staff reviews systems output and conducts preliminary reviews of providers to determine whether they can substantiate a pattern of fraud. In such cases, they must refer the matter to the States' fraud control unit for investigation.

Based on a review we conducted in November 1996, we determined that the number and percentage of suspected fraud referrals from SURS had declined in the previous 10 years. Officials at the State fraud control units were divided in their opinions as to the extent and quality of SURS development of fraud allegations and edits. Based, in part, on our recommendation, HCFA established a Program Integrity Group to address fraud and abuse issues within the Medicaid and Medicare programs. This group was charged with monitoring many projects that would increase the effectiveness of fraud unit activities.

*Managed Care Fraud*

Last summer, we released a report describing the manner in which Medicaid Section 1115 Waiver States detect, review, and refer for investigation fraud and abuse cases in managed care programs. This emerging area is of great importance as an increasing number of Medicaid beneficiaries receive health care services under managed care. In our review of 10 States we found variation in the intensity and nature of States' oversight activities for managed care fraud and that there is no general agreement about specific roles and responsibilities for fraud detection and referral in managed care. We recommended a series of actions for HCFA to undertake and work with us collaboratively, including establishing guidelines for States and managed care organizations to follow in developing and carrying out fraud and abuse detection and referral activities. Also, we recommended that HCFA ensure that States monitor managed care organizations' fraud and abuse programs for compliance with its guidelines. Finally, we encouraged HCFA to continue in developing and sponsoring training in managed care fraud and abuse referral and detection techniques for the States and Medicaid managed care organizations.

*Medicaid Payment Safeguard Activities*

We are in the process of conducting a study that will assess Medicaid program safeguards used in a sample of States and will provide information on the state of developing safeguards in the areas of provider enrollment, prepayment and claims processing and post payment review. We are finding several States are employing new safeguards in provider enrollment that show promising results in reducing the number of abusive providers within the program. States are now beginning to employ claims processing edits and other systems improvements similar to those used by Medicare that should reduce program vulnerabilities. Finally, we are seeing States begin to target their post payment activities to more accurately target fraud and abuse activities. All of these developments and new strategies suggest promising approaches that may be adopted by all of the State agencies and further strengthen the Medicaid program.

CONCLUSION

We appreciate the opportunity to come before you today and share with you the continuing improvements that we are witnessing in the ongoing fight against fraud and abuse in the Medicaid program. We will continue to work for further improvements that will strengthen the program through our investigations, financial audits and evaluations of program effectiveness. Perhaps most importantly, we look forward to continuing our active partnerships with other Federal and State agencies and to providing oversight and guidance in investigating fraud and abuse in health care. My thanks to you and the committee for highlighting this important issue and allowing us to share our continuing efforts. This concludes my testimony. I welcome your questions.

Mr. UPTON. Thank you very much.

Mr. Krayniak.

**TESTIMONY OF JOHN KRAYNIAK**

Mr. KRAYNIAK. Thank you.

My name is John Krayniak. I'm a Deputy Attorney General and the Director of the New Jersey Medicaid Fraud Control Unit. I appear today as a representative of the National Association of Medicaid Fraud Control Units.

In line with the Chairman's earlier statement, I would note that in 1965 the Medicaid program was $1.5 billion, and we've now gone to approximately $176 billion.

Mr. UPTON. Our population is getting older.

Mr. KRAYNIAK. Yes. For the first 10 years of the Medicaid program, Medicaid providers operated and billed with little or no oversight. In 1977, Congress, recognizing a need for an enforcement mechanism, passed the Medicare-Medicaid Anti-Fraud and Abuse Amendments which created the State-based Medicaid Fraud Control Unit program. States receive 90 percent of the startup costs for this program for 3 years, and thereafter the States receive 75 percent of the costs of running the Medicaid Fraud Control Unit.

The mission of the units is to investigate and prosecute provider fraud. It's also to investigate and prosecute abuse or neglect of patients in any facility that receives Medicaid dollars and also to investigate and, if necessary, prosecute fraud in the administration of the Medicaid program at the State level.

The Medicaid Fraud Control Units investigate and prosecute cases that range from street-level, drug diversion schemes to sophisticated white collar crimes. From one-defendant provider fraud cases to multi-defendant, multi-crime, multi-State conspiracies, the oversight is with the HHS OIG. Each unit must be initially certified, and each year the MFCU applies for a recertification.

There are currently 47 certified Medicaid Fraud Control Units. They comprise approximately 1,275 professionals, that is attorneys, auditors and investigators, that are organized into a strike-force-type investigative and prosectorial agency. Forty of us are in the State Attorney General's Offices.

Most of the units belong to their local, Federal and State Health Care Fraud Task Force and meet regularly with the U.S. Attorney's Office and other Federal agencies involved. To date, the units have achieved an enviable record, I believe, of over 9,000 criminal convictions.

Additionally, the units serve as a focal point for the Department of Justice in dealing with multi-State case settlements concerning providers that operate on a national basis. The units have participated in a number of these settlements that have resulted in a return to the Medicaid program of approximately $145 million.

I would like to speak for a moment about my association, the National Association of Medicaid Fraud Control Units. As I said, all 47 units belong. Our primary mission is for training. We conduct four training sessions each year to train and retrain auditors, investigators and attorneys, of course. Additionally, each unit provides in-service training, many of them going out to local and county police academies and giving instructions on investigation and prosecution of patient abuse.

We currently have 11 negotiating teams working with the Department of Justice on what we call global settlement cases, cases involving national providers that are ongoing right now.

That concludes my remarks, and I thank the committee for inviting me.

[The prepared statement of John Krayniak follows:]

PREPARED STATEMENT OF JOHN KRAYNIAK, DIRECTOR, NEW JERSEY MEDICAID FRAUD CONTROL UNIT

Mr. Chairman and Members of the Committee, thank you for the opportunity to appear before you today to discuss the role of the states in investigating and prosecuting Medicaid fraud. I am John Krayniak, Director, of the New Jersey Medicaid Fraud Control Unit. I am very pleased to appear before you as the representative of the National Association of Medicaid Fraud Control Units of which I currently serve on the Executive Committee.

The skyrocketing costs associated with health care delivery and the continued "graying" of our population have resulted in an increased reliance upon government-sponsored programs such as Medicare and Medicaid to provide much needed health insurance to those who would otherwise go without medical care.

The Medicaid program, which was established to provide health care to indigent patients, has seen its enrollment explode. When the Program started, in 1965, Medicaid expenditures were $1.5 billion. Nationwide, the Health Care Financing Administration expected to spend more than $176.5 billion in FY 1998 to sustain the Medicaid Program. Medicaid recipients increased from about 10 million in 1967 to a projected 36.7 million in FY 98, an increase of 267 percent. States are responsible for up to 50% of the cost of the Medicaid programs and some states now spend between 15 to 20% of their total budget to sustain the program.

This nation is expected to spend more than $1 trillion on health care or 15% of our gross national product this year. Given these figures, it is not surprising that our health care delivery system has proven ripe for fraudulent activity.

The General Accounting Office (GAO) has estimated that fraud and abuse accounts for 10% of health care costs and while there may not be a way to establish a precise figure, we are certainly talking about many hundreds of millions of dollars of fraud and abuse in the Medicaid program alone. In Congressional testimony, GAO has stated that only a fraction of health care fraud is identified and prosecuted. More than 20 years after the creation of the Medicaid Fraud Control Unit program, new fraud schemes continue to be uncovered as providers become more sophisticated and are able to detect new weaknesses in the system.

During the past decade, in particular, we have literally seen a feeding frenzy on the Medicaid Program, an unprecedented period in which wave after wave of multi-million dollar frauds have swept through nursing homes and hospitals, to clinics and pharmacies, durable medical equipment (DME), radiology and labs, and more recently, home health care. Although we do the best we can to put an end to program vulnerabilities, we still have profiteers who search and succeed in finding the next great loophole in the Medicaid system.

STATE MEDICAID FRAUD CONTROL UNITS

While the investigation and prosecution of health care fraud has only recently become a top national law enforcement priority, the states have been combating Medicaid fraud for more than 20 years and are viewed as leaders in the detection and prosecution of fraud in the health care industry. Medicaid, established by Congress in 1965 is of course, the primary government health care program for approximately 36.7 million of America's poorest and oldest citizens. For the first decade after Medicaid was created, the system operated with few controls against fraud. Inadequate safeguards combined with multi-billion dollar expenditure levels made a substantial amount of fraud inevitable. The result was an unprecedented theft of government dollars as local prosecutors struggled with the difficult task of prosecuting these highly sophisticated crimes. Congress came to recognize an urgent need to address this loss after much media attention and Congressional hearings highlighted the theft of taxpayer dollars and the harm suffered by Medicaid patients who were deprived of basic medical care. The result was legislation to establish specialized state-based strike forces to police the Medicaid program.

In 1977, Congress enacted legislation, the Medicare-Medicaid Anti-Fraud and Abuse Amendments, P.L. 95-142 which established the state Medicaid Fraud Control Unit Program and provided the states with incentive funding to investigate and

prosecute Medicaid provider fraud and to prosecute the abuse or neglect of patients in all residential health care facilities which receive Medicaid funds. Federal financial participation (FFP) for the first three years of a Unit's existence is 90 percent of the costs incurred by a certified Unit in carrying out its responsibilities. Thereafter, the federal government continues to provide 75% of each Unit's costs after the three year start-up period with the proviso that the FFP for any one quarter may not exceed the higher of $125,000 or ¼ of the sums expended by the federal, state and local governments during the previous quarter in carrying out the state Medicaid program. All states are now at 75% FFP.

This funding formula allows the federal government to insure that each Unit's activities are directed exclusively at provider fraud, fraud in the administration of the Medicaid program and patient abuse, and not at crimes lacking an appropriate Medicaid nexus.

Although the federal regulations require the MFCUs to be annually certified by the Secretary of the Department of Health and Human Services (HHS), the Office of the Inspector General of HHS has been delegated the administrative oversight responsibilities for the Units. The Health Care Financing Administration (HFCA) was originally assigned the certification, recertification and general oversight responsibility of the MFCU program. However, it was soon recognized that the Units' activities were more closely related to the OIG investigative function. This transfer took place in 1979.

The enabling federal legislation emphasizes the necessity of having an integrated multi-disciplinary team of attorneys, investigators, and auditors in one office in order to successfully prosecute these complex financial crimes. The Units are required to be separate and distinct from the state Medicaid programs to avoid institutional conflicts of interest, and are usually located in the state Attorney General's office, although some Units are located in other state agencies with law enforcement responsibilities such as the state police or the state Bureau of Investigation. The Omnibus Reconciliation Act of 1993 required all states to have a Medicaid Fraud Control Unit by January, 1995, unless a state can demonstrate to the Secretary of the Department of Health and Human Services, (HHS) that it has a minimum amount of Medicaid fraud and that residents of health care facilities that receive Medicaid funding will be protected from abuse and/or neglect. Idaho, Nebraska and North Dakota do not have federally certified MFCUs. The District of Columbia is in the process of establishing its MFCU.

Since the inception of this pioneering program, 47 federally certified state Units have successfully prosecuted over 9,000 corrupt medical providers and vendors and elder abusers—convictions that would not have occurred without this vital piece of legislation. These 47 Units police most of the nation's Medicaid expenditures with combined staff of approximately 1,275 and a total federal budget of 95 million dollars. This amount represents a small fraction of the total Medicaid budget that the Units are responsible for policing. Unit size varies state-by-state and is dictated to some extent by the size of state's Medicaid program. In New Jersey, for example, our Medicaid budget is 6 billion dollars and the Unit employs 36 staff. New York is the largest Unit with approximately 280 staff and Wyoming is the smallest with four.

In addition to the criminal consequences of MFCU cases (repayment of restitution, overpayments, state exclusions, incarceration, and often the loss of certifications, the ability to conduct business and professional licenses), the criminal convictions of the Units become the basis for further federal actions. The federal actions that are reported by the Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) include the underlying state convictions, judgments, forfeitures, civil settlements, federal program exclusions, and civil monetary penalties. In fact, the majority of health care fraud convictions, penalties, and exclusions reported to you are based upon MFCU convictions. The MFCUs are the most efficient and effective law enforcement agencies in the battle against health care fraud and patient abuse.

## PATIENT ABUSE AND NEGLECT

The MFCUs success in detecting and prosecuting Medicaid provider fraud is widely recognized, it is perhaps less well known that the Units are the only law enforcement agencies in the country specifically charged with investigating patient abuse and neglect.

In the mid-1970's, allegations of nursing home patient abuse shocked the country, causing universal outrage and a demand for effective redress. Implicitly acknowledging that patient abuse matters were the "orphans" of local prosecutors' caseloads—they having neither the time nor the expertise required to consistently pros-

ecute such matters successfully—Congress conditioned each state's participation in the MFCU program upon its formulating "procedures for reviewing complaints of the abuse and neglect of patients of healthcare facilities which receive payments under the State [Medicaid] plan" and, where appropriate, prosecuting such cases or referring them to other state agencies for prosecution (42 U.S.C. § 1396b(q) [4]; 42 CFR § 1007.11[b]). In accordance with that mandate, today each of the 47 currently enrolled MFCUs devotes a substantial portion of its caseload to patient abuse investigations. State Medicaid Fraud Control Units review thousands of referrals alleging patient abuse, neglect and the misappropriation of patient funds.

Patient abuse can be classified into several categories. For example, providing inadequate medical or custodial care or creating other health care risks may constitute patient neglect. Physical abuse includes acts of violence such as slapping, kicking, hitting or punching a patient and sexual abuse. Financial abuse includes the misappropriation of patients' personal funds such as commingling patient and facility funds or using patient funds to pay for facility operations.

Scores of investigations and years of cumulative experience have made it clear that the abuse, neglect, mistreatment, and economic exploitation of nursing home residents is a problem of far greater magnitude than previously thought. Eleven years ago, our national association, in collaboration with the National Association of Attorneys General (NAAG), responded to the growing national concern about patient abuse by adopting *Guidelines and Commentary for Legislation to Prohibit Patient and Resident Abuse.* These Guidelines are designed to encourage states to enact patient abuse statutes that would not only provide the necessary prosecutorial tools and enhanced penal sanctions for combating this type of shocking misconduct, but would also serve as a powerful deterrent to potential patient abusers.

It is difficult to conceive of a more vulnerable, less threatening group than residents of long-term care facilities. Yet, too often, they are the target of cruel and, at times, sadistic violence and mistreatment. Most reprehensibly, in long-term care facilities, perpetrators of physical abuse are usually those charged with care and well-being of patients. For example:

A New York physician was criminally prosecuted for willful neglect and reckless endangerment of a nursing home patient in his care. He mistook a peritoneal dialysis catheter in the patient's abdomen for a feeding tube, and ordered that she be fed through the catheter. When this error was discovered two days later, he made a conscious decision to do nothing to help the patient despite expert advice that the patient required hospitalization for treatment. Finally, ten hours later, the physician agreed to transfer the patient to the nearby hospital for care.

In Louisiana, a former certified nursing assistant trainee was arrested for raping a mentally ill woman in a nursing home and lying about his criminal record to get a job.

In Arizona, a residential care home owner was sentenced to serve 21 years—the longest sentence for elder abuse in the state's history—for neglecting and abusing his aged patients. To induce families to place their relatives in his facility, the defendant had lied to them about his licensure status.

Six physicians who worked at a facility for mentally retarded patients in Pennsylvania were arrested for allegedly abusing their patients and five were charged with the simple assault and neglect of a care-dependent person for allegedly using staples and sutures to seal wounds without the use of anesthesia.

Beverly Enterprises, Inc., the largest nursing home chain in the nation, agreed to pay $600,000 to improve care at their 17 facilities in the state of Oregon, after an MFCU investigation of a Beverly home found evidence of inadequate staff training and supervision, and other conditions constituting an immediate threat to resident health and safety.

71 felony charges were filed against nine individuals and three corporations involved with four Michigan nursing home facilities for criminal patient abuse and neglect and falsification of records at the facilities. A Michigan nursing home and its owner/administrator were charged with one count of involuntary manslaughter for the drowning death of an elderly patient who drowned in scalding hot water.

And beyond these egregious cases, the Units have also uncovered thousands of incidents of individual nurses, aides, and orderlies, raping, sodomizing, beating, kicking, and force-feeding the helpless, often incompetent patients in their charge.

Congress enacted P.L. 95-142, not only because of the widespread evidence of fraud in the Medicaid Program, but also because of the horrendous tales of nursing home patient abuse and resident victimization—and the Units are justly proud of their record in protecting the frail and vulnerable institutionalized elderly.

PROVIDER FRAUD SCHEMES

In the past decade, the MFCUs have seen a rapid increase both in the number of fraudulent schemes and the degree of sophistication with which they are committed. Although the typical fraud schemes such as billing for services never rendered, double billing, misrepresenting the nature of services provided, providing unnecessary services, false cost reports and kickbacks still regularly occur, new and often innovative methods of thievery have consistently occurred and are even just beginning to appear.

Medicaid fraud cases run the gamut from a solo practitioner who submits claims for services never rendered to large institutions which exaggerate the level of care provided to their patients and then alters patient records in order to conceal that lack of care. MFCUs have prosecuted psychiatrists who have demanded sexual favors from their patients in exchange for prescription drugs, nursing home owners who steal money from residents, and even funeral directors who bill the estates of Medicaid patients for funerals they did not perform.

The following are typical schemes corrupt providers may use to defraud the Medicaid program.

1. *Billing for services not rendered*—A provider bills for services not rendered, x-rays not taken, a nursing home or hospital continues to bill for services for a patient who is no longer at the facility either due to death or transfer, and psychiatrists bill for SSI qualifying exams which do not occur.
2. *Double-billing*—A provider bills both the Medicaid program and a private insurance company (or the recipient) for treatment, or two providers request payment on the same recipient for the same procedure on the same date.
3. *Substitution of generic drugs*—A pharmacy bills the Medicaid program for a brand name prescription drug, when a low cost generic substitute was supplied to the recipient at a substantially lower cost to the pharmacy.
4. *Failure to refund unit dose prescriptions*—Many nursing home pharmacies dispense drugs using the "unit dose" method, where a month's supply of pills are dispensed in sanitary bubble packs holding individual doses. The prescriptions are billed to Medicaid when dispensed, usually at a premium because of the extra effort involved in the unit dose packaging. Those medications which are not used should be, but often are not, credited to Medicaid. The percentage of returned medication is high in a nursing home because of the large number of mid-month medication changes, hospitalizations, and "use as needed" medications in the nursing home industry.
5. *Unnecessary services*—A physician performs numerous tests which are medically unnecessary and result in great expense to the insurer. Extreme examples noted in many states include "gang banging," where a single optometrist, podiatrist or other specialist will be allowed to treat the entire nursing home population in a day, regardless of whether the service is medically necessary for the particular patient being seen.
6. *Upcoding*—A physician bills for more expensive procedures than were performed, such as a comprehensive procedure when only a limited one was administered, a psychiatrist bills for individual therapy when group therapy was given.
7. *Kickbacks*—A nursing home owner requires another provider, such as a laboratory, ambulance company or pharmacy, to pay the owner a certain portion of the money the second provider receives from rendering services to patients in a nursing home. This practice is particularly costly because we find that it encourages the nursing homes, which act as gatekeepers for the ordered ancillary services, to subscribe to unnecessary ancillary services which are reimbursed by Part B Medicare and Medicaid.
8. *False Cost Reports*—A nursing home owner or operator includes inappropriate expenses for Medicaid reimbursement.

NEW SCHEMES AND TRENDS

Over the past few years, these so-called "typical" schemes have given way to more innovative ones. Recently, the Units have identified serious fraud problems in several industries including laboratories, home health care, medical transportation, durable medical equipment and pharmacies. The incidence of illegal drug diversion has risen sharply over the years, carrying with it a dramatic financial impact on the Medicaid program.

More and more states are enrolling their Medicaid population into managed care plans. While proponents of the managed care system believe that it is the best method for providing low cost high quality health care to more people, the experience of the fraud Units reveal that no health care plan is immune from fraud and indeed fraud does occur in managed care plans.

Recent global settlements of cases involving multiple state and federal entities have encouraged cooperative federal/state efforts to protect the Medicare/Medicaid programs from health care providers or vendors whose activities know no borders.

FRAUD IN NURSING HOMES

The Medicaid program still continues to finance the largest percentage of total costs for nursing homes. In 1997, total Medicaid vendor payments were approximately $123 billion dollars. Approximately 30.5 billion of this amount went to nursing facility services which includes skilled nursing facilities (SNFs) and all other categories for Intermediate Care Facilities (ICF), other than mentally retarded (MR) services. The number of skilled nursing facilities has been increasing since the 1970's and by the beginning of 1998 reached 14,860, an increase of 4.8 percent since 1997.

Traditionally, nursing home prosecutions involve the filing of false cost reports, which were proven false because they claimed reimbursement for expenses which were not properly attributed to patient care. The following are examples of nursing home fraud:

The Maryland MFCU has criminally prosecuted owners and administrators for including in their nursing home cost reports the following; the cost of renovating their personal residences, buying shrimp and tenderloin for holiday entertaining, including personal maid service and opera tickets on a cost report; fixing up rental properties for the benefit of the owners and paying a salary to a son who was in prison in Texas at the time he was drawing the salary.

Two Atlanta businessmen entered guilty pleas in federal district court to felony charges related to a complex scheme of submitting fraudulent nursing home cost reports to the Georgia Medicaid program. As a part of their guilty pleas, the pair agreed to pay restitution of approximately $6 million to the Georgia Medicaid program and also agreed to the forfeiture of an additional $2.155 million in assets.

South Carolina's first criminal conviction following the Unit's creation in 1995, was a management company that operated a nursing home. The company illegally received almost $50,000 in Medicaid funds for a patient who had already been discharged.

The former administrator of a nursing home in Nevada pleaded guilty after the Unit charged him with falsifying reports to the state by reporting nurse staffing hours in excess of the Medicaid regulations minimum requirements, when in fact, the actual hours of direct care were below the minimum levels.

In Pennsylvania, a nursing home owner and his corporation pleaded guilty to Medicaid fraud for illegally collecting over $120,000 by claiming reimbursement for personal, family and non-reimbursable business expenses. These expenses included vacation trips, entertainment costs, maintenance and home-improvement expenses for his personal residence and health and life insurance for his family. In addition, the owner fraudulently inflated reimbursement expenses for the nursing home by submitting in his cost reports operating expenses of two separate personal care boarding homes that he also owns.

In Washington State, a nursing home owner and administrator were convicted for billing the Medicaid program for hundreds of thousands of dollars for the full cost of patients who were concurrently being billed to Medicare.

For the first time in Ohio, the owner/operator of a group of nursing homes was convicted of money laundering after a 3½ year investigation for receiving $23,000 more than he was entitled to from the Medicaid program.

LABORATORIES

Aggressive marketing techniques, not traditionally associated with the health care industry, have increased costs by adding marginally necessary or totally unnecessary tests to health care bills. One such example are the recent Labscam cases where physicians were misled into ordering a rare, but expensive, diagnostic tests when they needed only an inexpensive and basic blood chemistry. Investigators found that several independent clinical laboratories induced doctors to order laboratory tests which were medically unnecessary by assuring that the additional tests would be free or of minimal cost. In fact, the laboratories were billing government insurers for these tests without the referring physician's knowledge. As a result of this three-year task force effort targeting unbundling schemes, federal and state governments were paid a total of $642 million to settle potential civil and criminal liability.

Billing for useless laboratory tests and cheating both government and private insurers is still occurring. In Maryland, a laboratory and its owner were found guilty

of numerous counts fraud and theft. The defendants were charged with billing government and private insurers for performing more than 8,000 unauthorized and useless diagnostic tests totaling nearly $150,000. The owner was also convicted of representing a laboratory which was in violation of the state's quality assurance laws. He was sentenced to serve five years in and ordered to pay $161,000 to Medicaid, Medicare and several commercial health insurance companies.

The Illinois MFCU charged several defendants with allegedly establishing a phony lab and billing Medicaid and private insurance companies for lab tests that allegedly were never performed by the lab. During a search of one of the defendants' home, tubes of what appeared to be human blood were found in the garbage can. Before the scheme was exposed, over $300,000 in payments from Medicaid and insurance companies passed through the corporate bank account.

Laboratories that provide drug testing for substance abuse programs have also been the subject of MFCU investigations. The Massachusetts MFCU indicted a drug testing laboratory and its president for allegedly overcharging Medicaid for tests it performed and then used in a series of fraudulent billing schemes to increase their billings even more. In Pennsylvania, a laboratory agreed to pay $750,000 to settle allegations that it overcharged the state for testing done for drug and alcohol facilities and hospitals in the Pittsburgh area.

Defendants across the country have found a way to turn blood into money. Clinic owners purchase human blood from "blood brokers." These brokers draw many vials of blood from people willing to sell it. These are often drug addicted individuals. The clinic owners pair these samples with fictitious laboratory requisition forms, using Medicaid recipient numbers drawn from their files. They order an expensive panel of tests which the laboratory performs. The laboratory then kicks back a portion of the Medicaid payment to the clinic owner.

In a New Jersey case exemplifying this scheme, a laboratory's Medicaid billings increased to $5.5 million from $500,000 in the previous year. During this investigation one defendant purchased vials of human blood from a cooperating witness. This was a "controlled sale" and the blood was drawn from state investigators who volunteered. Another defendant walked into an office where police were conducting an unrelated investigation with a bag containing vials of human blood.

Four defendants pleaded guilty and were sentenced to prison terms ranging from six to ten years. After a three week jury trial, another defendant was convicted and sentenced to one year in county jail.

Similar schemes have been detected in several other states. In California, a variation has emerged. It is called "dry labing." Instead of purchasing bogus samples from clinic owners lab operators merely submit electronic claims repeatedly. Trafficking in Medicaid identifiers is on the upswing.

## HOME HEALTH CARE

Already the fastest growing part of the Medicaid-funded health care system, state and federal outlays in the home health industry have ballooned in the last five years. The Medicaid federal share for home health care is expected to reach $18.4 billion by the year 2000. This increase is due to an aging population, shorter hospital stays, increasing cost of nursing home care and an increase in technology. Since the 1970s, technology has advanced to the point of allowing more and more patients to remain in their homes and receive treatment. The profile of a typical home health care recipient is one who is elderly, disabled, has AIDS, heart disease, diabetes or has been discharged from the hospital and needs more care.

Not only are home health care agencies charged with grossly inflating the number of hours their employees worked, but, more importantly, in some cases with recklessly sending untrained, unqualified, and unlicenced aides into private homes of thousands of critically ill and care-dependent patients. It is an industry that contains all of the components for disaster. It is unregulated in the traditional medical sense, multiple agencies are involved with large amounts of government money and it is attractive to the consumer.

Let me highlight a few examples of the Units' work in this area:

In California, an elderly man who died by starving and in his own filth, was locked in a room by his sons and daughter while they enjoyed Thanksgiving dinner in another room. They were his government paid home health caregivers.

Five individuals in Massachusetts were charged on a variety of Medicaid fraud charges as a result of the MFCU's investigation into Medicaid's personal care attendant program which allows disabled individuals to remain in a community setting with the aid of personal care attendants. Each of the defendants

charged the stated for services which were not provided and/or inflated billings made to the agencies.

In Pennsylvania, after a four week trial, a home health care agency owner and her corporation were found guilty for engaging in a 5½ year scheme to defraud Medicare and Medicaid of over $1 million. Evidence presented at trial revealed that the owner falsified records regarding patient homebound status.

Two home health care providers continued to bill the Washington State Medicaid program after the patients had died. In one of these cases, the defendant continued to bill the state while living with the victim's ex-wife.

A certified nurse's aide in Maine was sentenced to three years in jail, with all but 30 days suspended, and to four years probation for adding her name to a number of credit cards that belonged to the patient and making purchases on those cards totaling $7,196.13.

A major home health care agency settled with New York for 1.75 million dollars for submitting tens of thousands of inflated bills to Medicaid covering 1.2 million hours of services from 1994 to 1997.

Among the most rapidly growing segments within the home health care industry is home infusion treatments. Home infusion treatments include more than the actual medication. In addition to drugs and nutritional formulas, supplies such as tubing, syringes, alcohol swabs, bottles, gloves and needles, and expensive equipment such as pumps, nebulizers, glucose monitors and blood pressure kits that are regularly utilized by the victims of these serious illnesses, all of which are billed on a regular basis.

A large amount of the funds, too, are spent in the area of home care services. Regular visits, frequently more than once a day, by an R.N., nurse practitioner, home health aide, a physicians's assistant or even a physician, are required and reimbursed. Further, regular visits to a physician for certification of continued need and dosage adjustment are necessary. Again, a classic recipe for fraud with fragmented billings; drugs are billed by the pharmacies; the supplies used to assist in administering the drugs are billed by the DME provider; professional services are billed by the home health service company or individual providers; and personal services may be billed to various agencies.

The potential for fraud in this rapidly-expanding and highly expensive industry is clear. Kickbacks to doctors to authorize medically-unnecessary treatment, services or supplies, whether provided or not, is cause for MFCU concern.

MEDICAL TRANSPORTATION

Virtually every state MFCU has found egregious examples of fraud by non-emergency medical transportation companies. Medicaid will generally pay for a patient's transportation to a medical provider either when mass transit is unavailable in the recipient's area or when the patient, because of a debilitating physical or mental condition, cannot use this method of transportation. Examples of medical transportation fraud include; billing for an excessive number of miles per trip for services actually provided, billing for recipients who drove themselves, paying kickbacks to recipients who used the medical transportation services, allowing non-eligible persons to use another recipient's card, submitting falsified appointment dates for round-trip transportation services to a provider's offices, charging billing for emergency transportation for non-emergency situations, billing for fictitious services not covered by the Medicaid program or for transportation that was not provided, creation of phoney certificates of need ostensibly by doctors, and kickbacks to doctors for improperly certifying the need.

Transportation fraud is also committed by ambulance providers as well. For example, in Pennsylvania claims were filed to the state requesting reimbursement for ambulance trips that were not medically necessary. Many of these trips were to doctors' offices, which are not reimbursable under Medicaid regulations, but were misrepresented as being trips to hospitals. A Minnesota company that provided ambulance and medical transportation reached a $3 million dollar settlement with state and federal authorities for falsely billing the Medicaid and Medicare programs. The company billed these programs for basic life support ambulance transportation, claiming that the rides were medically necessary, when a lesser form of transportation would have been adequate.

A Florida task force investigation into false billings for the transportation of Medicaid patients resulted in 31 convictions of company executives, dispatchers and drivers. Due to lack of program oversight, companies with only one or two old vehicles were able to generate millions of dollars in false billings to the Medicaid program. It is estimated that over 18 million dollars was stolen from the program in South Florida alone.

The general transportation program in Maryland virtually collapsed under the weight of fraud and abuse. In 1988, the program cost taxpayers $4.5 million per year. Fraud, abuse and aggressive marketing caused the demand for program services to increase four fold in four years, for a cost of $16.2 million in 1992, at which time it was abolished.

In California, a state that pays for almost no transport services, nearly $1 million was recovered from bank accounts hours before the money was to be transferred out of the country. The defendants had already fled. They had used a combination of phoney certificates of need, lying about the mileage and kickbacks to board and care operators for access to Medi-Cal patients.

In Arkansas, as a result of a search warrant of one cab company, 16 former drivers of the company, nine Medicaid recipients and three others were convicted and were ordered to pay over $2 million in restitution to the Medicaid program.

## DRUG DIVERSION

Drug diversion or more properly the diversion of legal drugs for illegal purposes in the Medicaid program, has generated a supply of dishonest health care providers who both abuse their prescribing privileges and incur great costs to prescription plans, such as Medicaid. In large urban centers, it is not uncommon to find a so-called "pill mill" which has as its primary purpose the issuance of prescriptions for controlled drugs in exchange for cash or, in some cases, sexual favors. These drugs may then be resold "on the street" or sent abroad for black and gray markets for several times their cost, sustaining the continued addiction of countless individuals. In some instances, we have found that the street addicts resold the prescription drugs to other pharmacies at a fraction of their original cost and at some risk to the unsuspecting customers of the second pharmacy.

However, while drug diversion is often used in the context of pill mills and script selling doctors, the definition should include such cases as nurses who work in nursing homes who order prescriptions from pharmacies without a physician's order and then obtain the prescription from the pharmacy delivery person and either sell the drugs or use the drugs for themselves.

The larger point-of-entry cities of the United States have noted so-called "hit and run" schemes in which foreign nationals fraudulently obtain a Medicaid provider number and then submit invoices for services not rendered. In larger cities, these fake providers often are able to obtain hundreds of thousands of Medicaid dollars before their detection, at which time they flee to their homeland. In one such case in New York, the perpetrators went so far as to establish a medical laboratory and then offer to buy the blood of Medicaid patients for $10 a pint. Once the owners of the laboratory obtained the blood and the Medicaid eligibility numbers of the patients, they would submit astronomical bills to Medicaid, representing that they had performed an extensive and costly blood work-up, the results of which the patients would not receive. The laboratory owners were discovered only when numerous "patients" began appearing at hospital emergency rooms after selling excess amounts of blood and rendering themselves gravely ill.

In many of the nation's larger urban centers, it is not uncommon to find so-called "pill mills"—medical centers whose primary purpose is the issuance of prescriptions for controlled drugs in exchange for cash. In a typical scenario, a "patient" will visit an unscrupulous doctor and buy, for instance, a prescription for 90 Valium (10 mg) tablets at a price of about $1 a pill. After "busting" the 'scrip (having it filled) at an accommodating pharmacy, the patient will resell the pills to individuals at $5 a pop and thereby net a profit of $360. Not factored into this economic equation, however, is that each participant in the scheme is sustaining the continued addiction of countless individuals.

## FRAUD IN MANAGED CARE

Both the Medicaid and Medicare programs are utilizing managed care delivery systems. In some states, managed care has been in existence since the early 1980s. Currently, more and more states are requiring greater numbers of their Medicaid population to participate in their managed care programs.

Proponents of the managed care system believe that it is the best method for providing low cost, high quality health care to more people. Managed care is supposed to save money not only in the delivery of services but by cutting down on the amount of paperwork. While many observers point out that the very nature of managed care prevents fraud, the experience of the Medicaid Fraud Control Units, demonstrates otherwise. Rather, fraud simply takes different forms, in response to the way the program is structured.

In the traditional fee-for-service fraud, the healthcare provider is generally the one who commits the fraud. However, in managed care, fraud can be committed by a managed care organization (MCO), a contractor, subcontractor, provider, state employee, or beneficiary.

Managed care fraud includes the following:

Fraud in the procurement of the contract with the state Medicaid agency by the MCO;
Fraud committed in procuring provider subcontracts;
Falsification of financial solvency by the MCO;
Marketing and enrollment fraud, such as, enrolling ineligible or non-existent individuals;
Kickbacks for referrals to specialty physicians; and
Underutilization or the failure to provide adequate or timely reasonably accessible medical services to a patient for whom the provider has accepted a duty of care.

Marketing abuses are among the most prevalent type of managed care fraud. In almost all instances, this type of fraud occurs in the Medicaid HMO setting. Marketing agents fraudulently enroll Medicaid recipients by giving them false information, often without the recipients' knowledge. In many instances, persons are enrolled who are not Medicaid-eligible, such as prisoners. Many states have taken active measures to prevent, or at least reduce, this type of fraud, such as forbidding the direct solicitation of recipients by the HMO.

One of the first managed care fraud cases involving marketing schemes occurred in Tennessee. OmniCare, Tennessee's fourth-largest TennCare provider, employed marketing representatives who were paid a fee to enroll individuals in the health plan. Approximately 4,500 fictitious applications were submitted to TennCare and TennCare paid approximately $1.8 million to OmniCare for these enrollees. This money was subsequently recouped. Four marketing representatives were charged in a 28 count indictment for mail fraud, false statements, social security violations and conspiracy. Two of the defendants pleaded guilty. One was sentenced to 12 months and one day incarceration, three years supervised release and ordered to pay restitution of $5,000 to OmniCare. The other defendant was sentenced to three years probation and restitution of $246,400 to OmniCare. The remaining two defendants went to trial and were found guilty on all counts. One defendant was sentenced to 27 months incarceration, three years supervised release and restitution of $126,800. The other defendant was sentenced to 68 months incarceration and ordered to pay $1.4 million in restitution to OmniCare.

In Florida, Care Florida Health Plan, a health maintenance organization, paid the state $1.75 million dollars to settle allegations that it improperly enrolled Medicaid patients in the plan. California, Illinois, Maryland and Pennsylvania have also had cases involving marketing abuses.

The Maryland MFCU obtained convictions of 24 individuals for crimes related to the marketing of HMO plans to Medicaid recipients. The investigation resulted in charges against 14 HMO marketing representatives representing four of the five HMOs doing business in Maryland's Medicaid market, two HMO supervisors and eight Department of Social Service (DSS) employees. The crimes were based on bribing program employees in order to induce disclosure of Medicaid recipient information and forged or fraudulent enrollments, often made possible through use of the improperly disclosed information. These convictions resulted in the stronger regulations for HMOs doing business in Maryland and prohibition of HMO marketing at DSS offices and allowing the state to impose fines of up to $10,000 for fraudulent marketing practices.

For the first time, an MFCU has convicted a managed care organization and its top executive for stealing hundreds of thousands of taxpayer dollars from patients and participating doctors. The New York Medicaid Fraud Control Unit charged the owner and CEO with stealing more than $300,000 and defrauding 79 of the plan's participating doctors by engaging in an elaborate "bust out" scheme that improperly removed thousands of patients from these physicians' rosters. The CEO, who paid physicians based on the number of members assigned to them, instructed his staff to illegally remove approximately 6,700 patients from physicians' rosters during a two month period enabling him to reduce his expenditures and divert the savings to his company. He entered into a plea bargain which provides for the repayment of $375,000 to the Medicaid program.

The National Association of Medicaid Fraud Control Units (NAMFCU), which represents the 47 state MFCUs, adopted *Model Criminal Enforcement Statutes for Managed Care* in October 1996. This model criminal legislation is designed to provide a framework for the states to redress fraud in a managed care environment by criminal prosecution. In considering the adoption of any or all of the proposed model, states should examine their respective existing laws with regard to false

claims, false statements, unfair competition, unfair business and deceptive marketing and antitrust to determine whether new laws are needed.

Managed care fraud is more difficult to detect, investigate and prosecute than the traditional fee-for-service Medicaid provider fraud. There are a number of reasons that make managed care fraud cases more difficult. These include the complexity of the contractual agreements, the lack of referrals from the Medicaid agency and of reporting requirements, and the failure many times by the Medicaid agency to recognize that fraud does occur in managed care.

### MULTI-STATE/FEDERAL COOPERATIVE EFFORTS

Cooperative efforts between state and federal authorities have proven very effective in protecting Medicaid and Medicare from health care providers or vendors whose activities involve both programs and cross state lines. Joint federal and state task forces have been established in states throughout the nation, and agents increasingly are working together to detect fraud against government insurers. One side effect of these efforts has been the recognition by seasoned practitioners that *all* parties must be at the table when any case resolution is discussed. A settlement reached with a state Medicaid Fraud Control Unit in which all Medicaid claims are resolved, for example, does not necessarily resolve those in other states or any outstanding Medicare claims or their attendant sanctions. The result has been an unprecedented willingness on the part of state and federal authorities to reach "global" settlements in which all outstanding claims by government insurers can be resolved, and in which all administrative sanctions can be addressed. Unlike state consumer protection or antitrust multistate settlements, where the states determine that a market problem exists and appoint a lead Attorney General as negotiator, MFCU global settlements are generally based upon a federal Medicare investigation and prosecution. The federal government realizes that the states must be included in these cases because they would be unable to settle the Medicaid portion without them.

The federal government also understands that defense attorneys are unlikely to settle a case without the effected state settlement agreements. Most states, like the federal government, have the authority to exclude a convicted provider from their health care programs. It would make the settlement of these cases impossible if defense attorneys had to obtain settlement agreements from individual states and had to negotiate separate terms with each state.

In 1992, for the first time the state MFCUs participated in a global settlement, *U.S. v. National Health Laboratories, Inc.* (NHL). Since that time, the MFCUs have participated in the successful conclusion of ten global settlement cases with a total Medicaid recovery of almost $145 million dollars.

### RELATIONSHIP WITH THE S/URS UNITS

Federal regulations require state Medicaid agencies and MFCUs to enter into a Memorandum of Understanding (MOU) in which the agencies agree to refer all cases of suspected fraud to the Unit. In addition, the agency must afford the Unit access to their records. The Surveillance and Utilization Review Subsystem (S/URS), a subsystem of the Medicaid Management Information System (MMIS) which applies automated post-payment screens to Medicaid claims to identify aberrant billing matters, is the entity within the state Medicaid agency that refers suspected fraud cases to the MFCU. Established procedures for sharing Medicaid information between state officials, not only ensures referral of appropriate cases but also helps protect program integrity.

A number of reports have been issued assessing the effectiveness of the process used by Medicaid agencies to refer possible fraud cases to the Units and have offered suggestions for improvements. The most recent report, *Surveillance and Utilization Review Subsystems' Case Referrals to Medicaid Fraud Control Units,* was published by the Office of Inspector General in November 1996. This report concluded that the number and percentage of suspected fraud referrals from S/URS to MFCUs had declined during the past ten years, S/URS employees do not have sufficient training to assure that they develop and refer suspected fraud allegations in a consistent and appropriate manner, and HCFA does not routinely monitor S/URS development to establish whether potential fraud issues are being appropriately and consistently analyzed and referred.

The report recommended several solutions that HCFA, in consultation with OIG, should consider, including the convening of a Medicare and Medicaid fraud and abuse task force to plan and implement improvements in fraud operations and the development and implementation of a comprehensive evaluation system for S/URS case identification, development and referral activities.

HCFA convened a Medicaid Fraud and Abuse Technical Advisory Group (TAG) in 1998 as a forum for the sharing of issues, resources, and experiences among the states to develop best practices and to advise HCFA on policies, procedures, and program development. Twelve states are represented on the TAG as well as representatives from the National Association of S/URS officials and Medicare. I was recently appointed the TAG representative of the National Association of Medicaid Fraud Control Units.

I would like to describe to the Committee the relationship between the New Jersey Office of Program Integrity (OPIA) which is part of the state Medicaid agency and is responsible for referring appropriate cases to the Medicaid Fraud Control Unit and the MFCU.

Regular meetings between the MFCU and OPIA managers and staff members have reduced the mistrust and have allowed the two Units to work more closely together. The two Units have established a series of regularly scheduled monthly meetings with more frequent meetings and telephone conversations as needed.

Monthly screening meetings are supplemented with meetings on specific cases or topics. In addition the MFCU Director updates to OPIA Assistant Director on all significant case activities by letter. In cases where an indictment is returned, an accusation is filed, or a civil settlement entered into, the MFCU Director writes and includes a copy of all appropriate documents.

One of the major sources of friction between Medicaid S/URS Units and MFCUs has been the inability of many S/URS Units to take action to stop incorrect payments to providers who were the subjects of MFCU investigations. The MFCU often requests that the S/URS take no further action while the criminal investigation is pending in order to assure that the actions of the S/URS do no interfere with or compromise the criminal investigation. Furthermore, the MFCU is often unable to share evidence gathered during the course of its criminal investigation with the S/URS because of rules or laws protecting the secrecy of grand jury proceedings. As a result, protecting the integrity of a MFCU investigation often means adversely affecting the financial integrity of the Medicaid program, at least on a temporary basis.

New Jersey resolved this dilemma several years ago when the MFCU and OPIA developed a unique procedure for striking a balance between the needs of the MFCU and those of the state Medicaid Agency. Under this procedure, the MFCU agreed in many cases to permit the Department to take whatever administrative action was necessary to protect the financial integrity of the New Jersey Medicaid program, including prepayment monitoring, withholding payments pending conclusion of the criminal investigation in accordance with 42 CFR 455.23, and/or exclusion from the Medicaid program. Moreover, in cases where the MFCU is able to establish probable cause, search warrants are used in addition to or instead of grand jury subpoenas to gather evidence. The MFCU is therefore often able to share with OPIA the fruits of its criminal investigation while that investigation is in progress. In addition, the aggressive use of undercover operations has produced evidence that the MFCU is able to share with OPIA. This provides OPIA with the evidence and witnesses necessary to permit DMAHS to take summary administrative action to stop incorrect payments from being made to a provider while that provider is under criminal investigation without compromising the criminal investigation or violating grand jury secrecy. By resolving this dilemma, the MFCU and OPIA have eliminated a major source of controversy that has adversely affected the relationship between other MFCUs and S/URS throughout the country.

Additionally, the MFCU attempts to lessen the workload of OPIA when possible. Whenever a defendant pleads guilty to a criminal charge, the MFCU insists that the defendant sign a Consent Order of Debarment of Disqualification from the Medicaid program. The Consent Order specifies that the defendant has been advised of his right to a hearing on the subject of debarment or disqualification, understands it, and waives it by agreeing to be debarred for a minimum period of five years or disqualified for a minimum period of eight years. This Consent Order is placed on the record in open court, and the judge handling the matter also signs it. The Consent Order also provides that the defendant agree to the same period of disqualification from Medicare and any other state or federally funded health care program as agreed to regarding the Medicaid program. This Consent Order is immediately forwarded to OPIA. As a result, instead of securing approval from the Attorney General's Office for a pre-hearing suspension, issuing a Notice of Suspension, preparing for a hearing involving civil attorneys from the Division of Law within the Department of Law and Public Safety, and actually going through the hearing process with its inevitable delays and problems, OPIA simply prepares a Notice of Debarment or Disqualification, sends it to the provider, and notifies the agency's fiscal agent. The Consent Order and exclusion notice are also forwarded directly to the Office of the

Inspector General within the U.S. Department of Health and Human Services for appropriate federal action. Consequently, the resources OPIA would have expended on administratively prosecuting this suspension can be put to more productive use in other cases.

Finally, since OPIA was established in 1975, it has had two supervisors, both of whom were attorneys. One of the reasons for this was the belief by top management within the Medicaid agency that an attorney would be best suited by training and experience to understand and resolve the problems and issues that arise between a MFCU and a S/URS Unit. Conversely, it was felt that the MFCU chief would feel more comfortable in discussing legal problems and issues with another attorney. Furthermore, since 1979, OPIA has been headed by an attorney who was formerly a civil Deputy Attorney General (DAG) in the same department as the MFCU. This individual not only provided legal representation to the Medicaid agency and OPIA, but also worked closely with the MFCU while a DAG. Since 1979, he has made a close and productive working relationship between OPIA and the MFCU a top priority.

For all of these reasons, New Jersey's S/URS Unit and MFCU have developed a working relationship characterized by cooperation and mutual respect and as a result have enhanced New Jersey's Medicaid anti-fraud and abuse efforts.

NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS (NAMFCU)

The National Association of Medicaid Fraud Control Units (NAMFCU) was established in 1978 to provide a forum for the nationwide sharing of information concerning the problems of Medicaid fraud control, to foster interstate cooperation on law enforcement and federal issues affecting the MFCUs, to improve the quality of Medicaid fraud investigations and prosecutions by conducting training programs and providing technical assistance for Association members, and to provide the public with information on the MFCU program. All forty-seven MFCUs comprise the Association. Forty of the Units are located in the Office of the Attorney General and seven are located in other state agencies.

The Association employs a Counsel, located at the National Association of Attorneys General in Washington, D.C. The Association coordinates and disseminates information to the various Units, maintains a library of resource materials, and provides informal advice and assistance to its member Units and to those states considering establishing a Unit. NAMFCU has provided extensive training for MFCU staff over the years and is called upon regularly to supply speakers for numerous health care fraud seminars. It has also co-sponsored training programs with the F.B.I. and the American Bar Association and conducts a specialized academy at the Federal Law Enforcement Training Center. Most Medicaid Fraud Control Units provide training regularly within their own states at police academies on elder/patient abuse and for social service employees, community and provider groups on billing fraud issues as well as patient abuse. The *Medicaid Fraud Report,* published ten times a year, is the Association's newsletter. The newsletter contains information concerning prosecutions by various states, reports of legal decisions affecting fraud control prosecution, and analyses of legislation affecting the Medicaid program and MFCUs. NAMFCU also serves as a clearinghouse for state/federal cooperative efforts and provides a responsive voice to Congressional inquiries.

In closing, I want to emphasize that the Medicaid Fraud Control Units are viewed as having a national leadership role in detecting and prosecuting fraud and abuse in government funded health care programs. The Units have been successful in serving as a deterrent to health care fraud, in identifying program savings, removing incompetent practitioners from the health care system, and in preventing physical and financial abuse of patients in health care facilities.

Thank you again for the opportunity to testify today.

Mr. UPTON. Thank you very much.

Ms. Williams.

## TESTIMONY OF GWENDOLYN H. WILLIAMS

Ms. WILLIAMS. My name is Gwen Williams. I recently retired from the State of Alabama, having served 22 of my 25 years with the Alabama Medicaid agency. For the last 4 years, I served as commissioner of that agency and in that role served on the Executive Committee of the National Association of State Medicaid Directors. I participated with that organization in partnership with the

Health Care Financing Administration in the creation of a National Technical Advisory Group for Medicaid Fraud and Abuse.

I served initially as the liaison between the Executive Committee of the National Association of State Medicaid Directors and ultimately assumed the role as chair of the National Fraud and Abuse Technical Advisory Group.

I want to share with you just for a few minutes about that group and what it has done in the last 1½ years of its operation.

This group, which is a joint partnership between the State Medicaid directors and the Federal Government through HCFA, is chaired by a Medicaid Director. It is staffed by the American Public Human Services Association. So it is a joint partnership arrangement to provide an open forum for discussion of fraud and abuse issues.

In the 1½ years since its operation, the Technical Advisory Group has focused on common issues between the 50 States and the Medicaid programs. We have focused heavily on communication and have experienced some significant success in heads-up type information being shared between the States to alert sister States of fraudulent providers or fraudulent provider schemes before the other States are affected.

A recent case in point is the case of Indiana, which received that type of alert from the State of Florida, considerable distance, but as that heads-up information was distributed around the country by the State of Florida, Indiana found that that provider had, in fact, opened operation in Indiana and prevented the payment of $26,000 in claims that were currently pending in that State.

At another role that the TAG has played has been to identify emerging issues. As you have already discussed this morning, the Medicaid and health care environment is changing rapidly. It has become more and more complex, and as it has changed so has the type of problems with fraud and abuse in the program. The emerging issues that we have identified are things that have not really gained attention, such as personal care services in the home and the vulnerability of those patients for fraud and patient abuse in the home, for those unsupervised types of care.

The Technical Advisory Group has taken an active role in not only identifying these new issues but also strategizing ways to identify them, prevent them and, in the appropriate cases, identify for prosecution.

Another role that the Technical Advisory Group has been very successful in is developing best practices, as States have success in identifying fraudulent schemes, sharing that information with their sister States so that those States, too, can focus those best practices on their Medicaid programs.

One of the primary roles of the Technical Advisory Group and one I want to spend a little more time on this morning with you is in the area of legislation and regulation. There are a number of issues that the Technical Advisory Group has identified in the area of legislation that we believe will significantly facilitate States in their efforts to identify and prevent fraud and abuse in the Medicaid program.

The first such—there are three initiatives that the Technical Advisory Group presented last year and was endorsed by the National

Association of State Medicaid Directors and the American Public Human Services Association as being appropriate legislative initiatives for Medicaid fraud.

The first is what's commonly known as the 60-day rule. This is a requirement where every Medicaid program must refund to the Federal Government within 60 days any identified overpayment, whether or not that overpayment has been collected. Imagine, if you will, accepting a job paying, say, $100,000 a year, and you're notified immediately, even before your first paycheck, that you owe the full Federal income tax on that salary. This is the burden the States face when they identify overpayments for providers. This is a huge disincentive for States to actively pursue large, vulnerable prosecutions or identification of possible fraudulent schemes where the collection of that overpayment may be very risky.

Another issue that was identified by the Technical Advisory Group is in the area of recipient suspensions. Under the current Federal law, Medicaid recipients cannot be suspended from the Medicaid program unless they are convicted in Federal court of Federal Medicaid fraud.

Those of you that are familiar with the Federal courts know that Medicaid recipient fraud is not an issue, has never been an issue in law enforcement for Medicaid. Medicaid has focused exclusively on provider fraud. But I'm here to tell you the new and emerging schemes actively incorporate Medicaid recipients in those schemes, particularly in the area of pharmacy.

I heard mention this morning the concept of Medicaid as a credit card. This is a mentality that Medicaid recipients have held since the beginning of the program. It is something that Medicaid recipients feel is their right, to use their Medicaid card to purchase drugs through the Medicaid program that they in turn sell in the street, to work in concert with fraudulent Medicaid providers to cheat the Medicaid program.

I believe I'm out of time.

The ability of a State to suspend or terminate Medicaid recipients' participation in the program is a huge deterrent when that recipient understands the risk that they bear. It is also a huge incentive to encourage recipient cooperation in fraud investigations.

One solution that States believe is very appropriate is in the area of Federal matching funds. Currently, fraud and abuse activities at the State level are matched at 50/50.

You heard earlier that the Medicaid Fraud Control Unit activities are matched at 75 percent. There seems to be a problem here when the investigators—the costs of investigation is at 75 percent, but the State must put up half the costs of the salaries and benefits of those employees used to identify the suspected fraud.

I would encourage you to look at the CHIP model, the Child Health Insurance Program, as a model to encourage States to do more. The Congress identified a huge problem in the area of children's health insurance. They did two things—they gave States a financial incentive to address the problem through enhanced Federal matching. They also gave States broad flexibility on how to approach the problem within certain constraints and certain guidelines. I believe this is a model that will work in all areas of the Medicaid program and certainly in the area of fraud and abuse.

I will say that no one is more sensitive to the problems of Medicaid fraud and abuse than Medicaid directors. Medicaid directors are those individuals struggling with their limited State matching funds. They are acutely aware that every dollar spent inappropriately in the Medicaid program is a dollar they cannot spend on needed services to their customers, their clients, their recipients.

I appreciate the attention you're giving this issue. I appreciate the opportunity to come today and represent the Medicaid directors perspective, and I look forward to responding to your questions.

[The prepared statement of Gwendolyn H. Williams follows:]

PREPARED STATEMENT OF GWENDOLYN H. WILLIAMS, RENAISSANCE GOVERNMENT SOLUTIONS

Chairman Upton, distinguished members of the Subcommittee, and interested listeners, my name is Gwen Williams. I recently retired from the State of Alabama after twenty five years of service, twenty two of which were with the Alabama Medicaid Agency. During those years I served in many capacities, including that of Director of Program Integrity, and from January 1995 until January 1999 I served as Commissioner of that Agency. During my tenure as Medicaid Commissioner, I was honored to represent the Southeast as a member of the Executive Committee of the National Association of State Medicaid Directors (NASMD).

Emerging issues and challenges facing state Medicaid programs in recent years have created a landscape resembling that of a rugged and inhospitable wilderness. Program expansions, service demands, and escalating costs have created mountains of adversity which often obscure from administrative view other perils and pitfalls which threaten the integrity of the program. Fraudulent billing schemes, abusive overutilization, and collusion among providers all drain precious resources away from the vulnerable populations dependent on the program for their health and safety. Unqualified providers, inappropriate services and denial of needed care all threaten the Medicaid patients' safety and their trust in the health care delivery system.

State Medicaid Directors are not blind to these perils, and have consistently sought to respond to these threats in a timely and efficient manner. In the past few years, however, as more attention has been given to these concerns at the national as well as local level, a cooperative effort between state Medicaid programs and the Health Care Financing Administration (HCFA) has emerged. This effort will have the dual result in providing a forum for states to identify barriers to the prevention, detection and elimination of fraudulent and abusive practices within Medicaid and facilitating information available to the states about emerging fraud schemes and successful deterrent and detection methods employed by other states.

In August, 1997, the Health Care Financing Administration convened a focus group to discuss fraud and abuse issues within the Medicaid program. One significant result of this meeting was the creation of a national Medicaid Fraud and Abuse Control Technical Advisory Group. This group, commonly referred to as the Fraud and Abuse TAG, brought together state program integrity representatives from across the country, along with representatives from HCFA. The TAG is chaired by a Medicaid Director and staffed by the American Public Human Services Association. A member of the Executive Committee of the National Association of State Medicaid Directors serves as liaison to all TAGs, and I was selected to be the liaison to the new Fraud and Abuse TAG. I later assumed the dual role as chairman of the TAG upon the resignation of the original chair.

The mission of this TAG, as developed by its initial membership, is as follows: The TAG exists as a forum for the sharing of issues, solutions, resources, and experiences among the states to develop best practices; advise HCFA on policies, procedures, and program development; and make recommendations to APHSA regarding fraud and abuse policy and legislation changes in a coordinated effort to reduce resources that are lost as a result of fraud and abuse in the Medicaid program.

Since its establishment in early 1998, this TAG has worked diligently to fulfill its stated mission. Through the use of topical workgroups, the TAG has already accomplished many of its initial goals. A list of legislative proposals, which will be addressed in greater depth later in this presentation, was developed in the summer of 1998 and endorsed by both the National Association of State Medicaid Directors and the American Public Human Services Association. In addition, the Legislative

and Regulation Workgroup has also reviewed and provided comment on several legislative and regulatory proposals dealing with Medicaid fraud and abuse.

A Medicaid Fraud Statutes Web Site was developed by HCFA, in cooperation with state program integrity staff. This web site, located at http://fightfraud.hcfa.gov/mfs, contains a comprehensive listing of the best Medicaid fraud and abuse statutes among the states. The data base is indexed by subject matter, facilitating research into successful state legislative initiatives to combat fraud and abuse.

In 1998, a TAG workgroup developed and conducted a survey of state Medicaid programs to identify the top fraud and abuse issues, both administrative and programmatic, facing Medicaid programs in today's marketplace. Included in the survey instrument were questions regarding methods employed by states to prevent and correct fraudulent and abusive billing practices. The results of this survey affirmed the commonality of issues between the states and demonstrated a need for improved communication between states on successful methods to address those issues. The TAG concluded that the survey provided an appropriate segue to begin consolidation of "best practices" identified by states and Medicaid Fraud Control Units, and the subcommittee has proceeded with this effort.

Because of the significant fiscal impact of the pharmacy program to all states' budgets, the TAG established a Pharmacy Workgroup devoted to exploring fraud and abuse prevention methods and best practices in that program. While pharmacy specific legislation and policies vary greatly from state to state, the workgroup has identified a number of common concerns within that program. To expand on those common issues, the workgroup surveyed all states asking what successful actions each state has taken to address pharmacy fraud and abuse. The states were also questioned about actions they would take if given the authority. The workgroup is consolidating the findings of this survey into concise "best practices" which will be distributed to all states.

A critical component of the TAG's mission is to improve communication both between states and with HCFA. The TAG created a process of "fraud alerts" to disseminate emerging fraud schemes quickly among all states. The development of this process has already reaped significant dividends for the states. States are reporting successful intervention in preventing fraud by suspected providers and suspicious practices due to "heads up" information received through the TAG's communications network.

This communication network has also been beneficial to the states in providing immediate response to HCFA on legislative or regulatory proposals. This improved communication flow insures that states are afforded the opportunity to identify potential barriers and unexpected consequences of such proposals *before* they are adopted.

An important ongoing role for the TAG is the identification of emerging problems which impact the integrity of the Medicaid program and establishing dialog to address those problems. Currently, the TAG is actively addressing concerns with self-directed care services, such as home and community based services. Included in these concerns is the prevention and detection of fraud, qualifications of care providers, and reasonable standards and training on those standards for accurate documentation of services. Successfully addressing these concerns presents the added burden of balancing program integrity needs without undermining the self-directed care philosophy. Although the amount of fraud and abuse currently being detected in these services is small, the potential for loss to state Medicaid programs could be substantial, given that these programs can command up to 25 percent of the budget.

As previously stated, the Legislation and Regulation Workgroup identified a number of legislative initiatives which would improve states' efforts to prevent and detect Medicaid fraud and abuse. Three specific proposals were developed in 1998 and presented to HCFA with the endorsement of both the National Association of State Medicaid Directors and the American Public Human Services Association. Those three proposals are as follows:

1. Increase Federal matching funds for fraud and abuse activities from the current 50% to 75%. The increase in available matching funds could provide a significant incentive to states to increase resources devoted to fraud and abuse. Such costs would include salary and benefit costs for investigators and fraud auditors, travel costs, computer support (both hardware and software), and any other costs directly related and clearly identifiable with fraud activities.
2. Removal of the "60 day rule" for return of federal matching funds on all identified overpayments. This rule, which requires a state to refund the federal match on any identified overpayment without regard to its actual collection, creates a significant disincentive for states to identify overpayments of large amounts unless collection is assured and imminent. The collection process on fraud and abuse

cases is long and often volatile. States often negotiate repayment agreements that, while delaying collection, facilitate both the resolution of cases and removal or restriction of problem providers without protracted legal battles. A far more reasonable approach would be to require states to return FFP immediately upon collection, thus removing this barrier while preserving the appropriate return of federal funds.

3. Amend Title XIX to permit states to suspend recipient eligibility for a reasonable period for fraud or abuse of the program. Currently, Title XIX only cites conviction in federal court as grounds for suspension of Medicaid eligibility. Federal law enforcement officials have historically focused all attention on provider activities, without regard for recipient activities. As the Medicaid program has grown and become more complex, so have the opportunities for recipient fraud and abuse. Particularly in the pharmacy program, states are discovering organized and often wholesale efforts by recipients and groups of recipients to defraud the Medicaid program. Often these efforts are in concert with fraudulent efforts on the part of Medicaid providers. States desperately need the authority to suspend participation in the program by those recipients clearly found to have defrauded the program.

In addition to the above, the Legislative and Regulation Workgroup continues to identify legislative initiatives that could significantly improve their ability to identify and correct fraudulent practices. A current proposal which has not yet been presented to NASMD and APHSA relates to facilitating the use of cash rewards to Medicaid recipients who report provider fraud which results in a conviction. Currently, any such cash payment is applied to the recipient's income, which adversely affects their eligibility for coverage and creates a disincentive to the recipient. Legislation to exempt such rewards from eligibility determination will enable states to offer a specific incentive to recipients to report suspected fraud.

Another issue that would require legislative intervention is that of "fleeing felons". Welfare reform legislation specifically excluded Medicaid from provisions that make felons ineligible to receive government benefits. Not only are Medicaid benefits protected, but states are prohibited from performing data matches with Medicaid records to assist law enforcement in locating fleeing felons. Many states believe that this is contrary to maintaining the integrity of the program and should be amended.

In recent years, there has been a growing involvement by the Office of the Inspector General (OIG) in evaluation of states' and HCFA's efforts in the fraud and abuse arena. While the intent of these efforts is admirable and appropriate, they have themselves caused disruptions and difficulties to the states. Staff performing these reviews usually have no background in Medicaid and require extensive efforts by state program integrity staff to assist in them. In addition, demands for extensive technical and system support for their efforts further disrupt program integrity staff from their duties. Often, the methodology applied to the reviews is seriously flawed, and does not effectively address fraud and abuse.

For example, in the Single State Audit, in which the OIG enlists individual states' auditors to perform payment accuracy studies, the state is examined in four areas: medical necessity, proper documentation, incorrect coding, and non-covered services. States are being held accountable for the medical necessity and proper documentation of all services reviewed; however, without 100% prepayment review of all claims and removal of all timeliness requirements for claims payment, states cannot ensure that each and every service rendered is medically necessary and that the providers' supporting documentation is complete, correct, and legible. The result is a "double-whammy" to states-audit citation for issues not necessarily related to either fraud or abuse and significant disruption to program integrity efforts to truly address fraud and abuse.

It should be readily apparent why states are reluctant to eagerly support such efforts. It should likewise be apparent why there is little confidence by states in OIG's findings when the subject of such reviews.

It is often said that if you've seen one Medicaid program, you've seen one Medicaid program due to the varied approaches states take in operating their programs. This is also true in examining relationships between state Medicaid agencies and Medicaid Fraud Control Units, which range from a sense of shared purpose to raging animosity. In Alabama for example, the relationship has moderated somewhere between the two extremes, with periodic leanings in either direction. The success of a Medicaid Fraud Control Unit (or MFCU) is often perceived as directly linked to the effectiveness of the state's program integrity unit. While there is a great deal of truth in this assumption, there are many other factors that affect a unit's success.

The MFCUs have the dual responsibility of prosecuting Medicaid provider fraud and prosecuting patient abuse in nursing facilities. There are strong feelings on the

part of states that the added responsibility of patient abuse dilutes attention to Medicaid fraud. States often experience great frustration as MFCUs expend time consuming efforts in patient abuse cases, while the more difficult provider fraud cases languish, often past the statute of limitations for prosecution. There is a shared perception among state Medicaid agencies that local law enforcement agencies are more than capable of investigating and prosecuting patient abuse, and that those same local agencies resent the outside interference of the MFCUs. Provider fraud is far more difficult to investigate, and even harder to successfully prosecute. With pressure both from within the state and from the OIG to "produce", it is not surprising that MFCUs would look to patient abuse cases to demonstrate their effectiveness.

Another issue adversely affecting the relationship between state Medicaid agencies and MFCUs has always been the nature of referrals. States often feel caught in a "catch 22" with regard to when a case should be appropriately referred. They hear from their MFCU that they should refer any and all instances where fraud is suspected, but then complain that not enough verification was done to ensure a quality referral, thus wasting their investigative time. On the other hand, when states attempt preliminary verification on the existence of suspected fraud, they encounter sharp criticism from the MFCUs for potentially compromising the investigation.

The primary argument in the initial establishment of the MFCUs as separate and apart from state Medicaid agencies, was their ability to be "independent" of the program and its concerns. While this is certainly a noble motive, it has contributed greatly to the strained relationship between the two organizations. As state Medicaid agencies have come repeatedly under the gun for ensuring patient access to care, MFCUs are not so encumbered. Particularly in rural areas, where access to Medicaid providers has been a constant struggle for states, aggressive actions by MFCUs in performing sweeping reviews of specific providers (usually physicians) has created serious distrust in the program by providers, resulting in their withdrawal from the program. These "search and destroy" missions rarely uncover genuine fraud or billing abuse, but create havoc in provider practices. State Medicaid agencies are then left to pacify outraged provider groups and associations and try to avoid mass exodus of these providers from the program.

While Medicaid Fraud Control Units and state Medicaid agencies have a shared responsibility to attack fraud and abuse within the Medicaid program, the current statutory and regulatory relationship is seriously flawed. There has to be a better solution to enabling and empowering states in better investigation and prosecution of Medicaid fraud.

In conclusion, contrary to what you may think or hear, state Medicaid agencies are very concerned about the integrity of their program and committed to actions to prevent, detect, and eliminate fraud and abuse within the Medicaid program. Thank you for allowing me the opportunity to share the perspective of one Medicaid director.

Mr. UPTON. Thank you very much.

Mr. Fecteau.

## TESTIMONY OF MARC P. FECTEAU

Mr. FECTEAU. Chairman Upton, distinguished committee members, I'm here representing the National Association of SURS Officials, the State agencies who address fraud and abuse and waste. While others tend to concentrate on the fraud issues, our units are involved in all three areas. For example, a mental health agency that charges $300 for a 4-hour group therapy session and their supporting documentation states "they were here, I saw them," that's not fraudulent, but yet the State identified and recovered over half a million dollars in a case with this type of documentation in the charts.

The integrity units or SURS units recover millions of dollars over the years, but they also identify the fraudulent activities that come through. A psychological examiner that obtained the Medicaid ID numbers for entire families while serving as a school counselor and

billed over $150,000 of services on behalf of members, family members he had never seen.

The case reviews are time consuming. They involve medical records and so forth. Yet State integrity units remain understaffed. Some are still staffed at their 1985 levels. Since then, our provider base has tripled, our Medicaid expenditures are quadrupled. A few States have even experienced reductions in staffing, and one State had its entire understaffed unit replaced by a single individual with no experience in Medicaid fraud and abuse.

In addition to being understaffed, the units or most units are limited to 20-year-old technology, 1970's design. In an age where technological obsolescence is measured in days, then surely these systems are considered the dinosaurs of technology.

Even with these limitations, in a current survey going on right now, 20 States have responded they have identified over $240 million of fraud, abuse and waste in the last 2 years; and these involve a wide range of discrepancies, from the provider that billed the Medicaid program for lab cultures that he performed with a cardboard box and a light bulb to the multimillion dollar scams involving providers and clients buying and selling Medicaid ID numbers for the sole purpose of defrauding the Medicaid program.

The units also address recipient abuse of health care services. Through the lock-in program or restriction program, they can limit a client to one physician, one pharmacy and one hospital. The program attempts to curb the abuse related to prescription drugs, overuse of emergency room services—one client had 160 in 1 year. Calculating this cost savings is difficult, but one State did do that in 1990 when its two-person recipient unit was disbanded for cost savings purposes. But the study concluded that this program was saving nearly $1 million per year in this one State.

Unfortunately, the restriction program is not effective if a client is also on Medicare. Medicare does not have a comparable program. Therefore, a dual-eligible client can continue to abuse health care services. Medicare covers the physicians and the emergency room visits, but Medicaid pays the coinsurance, the transportation to each service, and the narcotics. This is an area in which we believe that HCFA could provide needed assistance and guidance.

It's important to state that the relationship between HCFA and the SURS units has made tremendous advances. The adversarial type relationship of only 5 to 6 years ago has been replaced with a partnership to address Medicaid fraud and abuse. But in the course of partnering toward a united goal, the basic SURS requirements needed for a State to be in compliance have been either eliminated or not enforced. Unfortunately, HCFA's good-faith effort to work with the States has been interpreted by some to mean that they can reduce their SURS administrative expenses and remain in total compliance.

Congress has made a commitment to address Medicare fraud. Now we ask that it make that same commitment to the Medicaid program. The commitment can be demonstrated in several ways.

First, Federal guidelines and requirements need to address the minimum standards for a compliant fraud and abuse function that indicates minimal staffing requirements. These minimal requirements could be based on a State's Medicaid expenditures, for exam-

ple. The guidelines should also establish on what constitutes sound technological tools, not 1970's mainframe computer systems.

The States could also receive an incentive for expanding their commitments by offering Federal funding at a 75 percent match for all State positions whose primary duties are related to Medicaid fraud and abuse.

Second, creative methods of funding the acquisition of technological tools could further enhance this commitment to the States. The Federal Government could offer to initially fund 100 percent of replacement fraud and abuse technology and allow the State to repay its share through its recoveries from fraud and abuse.

Third, a cooperative recipient utilization program needs to be established between Medicaid and Medicare. Millions of Medicaid and Medicare dollars are lost each year through abuse of health care services.

And, finally, the statute requiring States to reimburse the Federal financial participation portion within 60 days of notifying a provider of an overpayment needs to be eliminated. This statute basically penalizes States that actively pursue the waste found in their programs. Since both the State and Federal Government share in the cost of Medicaid, should they not also both share in the costs of reducing waste in a program?

The SURS units stand committed in the fight against Medicaid fraud, abuse and waste. We believe that we provide a solid foundation from which your commitment to effectively address these issues can become a reality.

Thank you for this opportunity to express our concerns. I will be happy to answer any questions.

[The prepared statement of Marc P. Fecteau follows:]

PREPARED STATEMENT OF MARC P. FECTEAU, PRESIDENT, NATIONAL ASSOCIATION OF SURVEILLANCE OFFICIALS

Chairman Upton, Ranking member Klink, distinguished Committee members, I wish to thank you for this opportunity to share the Medicaid fraud and abuse activities of the State agencies' Surveillance and Utilization Review Units (SURS) and Program Integrity Units.

The SURS and Program Integrity units monitor the Medicaid Program for fraud, abuse, and waste by conducting reviews or audits of health care providers and beneficiaries. From these case reviews the units often identify potential fraudulent activities and, as required by federal statute, refer these cases to the Medicaid Fraud Control Units. In most states, the SURS or Program Integrity Units remain actively involved during the fraud investigation.

Although fraud cases receive more publicity, abuse and waste in the Medicaid Program is certainly more prevalent. The states' integrity units are at the forefront of these case reviews. They routinely monitor, through actual medical record reviews, the services that are billed to Medicaid. Computer reports can assist in identifying the areas to be reviewed, but cannot replace the value and necessity of actually reviewing the record of service. What is Medicaid paying for? Should it pay $300 for a four hour group therapy session when the only documentation in the chart is "They were here, I saw them?" Or should Medicaid reimburse at $60 per session the substance abuse counselor that bills dozens of individual therapies that focus solely on finding a girlfriend for a client?

It is from these routine reviews that recoveries are made for abuse and waste, and where many fraudulent activities are discovered. For example, a routine review of another substance abuse counselor discovered that nearly every individual therapy session that was billed to Medicaid was in fact group services. Another routine review discovered a psychological examiner that had no documentation for any of the services billed to Medicaid. The SURS unit expanded its review and learned that the provider was the school district counselor and had obtained Medicaid ID numbers from the children's Medicaid cards. Subsequently, the SURS unit cal-

culated that up to 90% of the services billed had never been provided and over $150,000 of fraudulent billings were identified.

These units are the front line troops in combating fraud, abuse, and waste. In the mid to late 1970's, states implemented a computerized system that was initially designed to monitor the utilization of health care services paid for by Medicaid. The system soon became the primary tool for identifying potential fraud and abuse in the Medicaid Program. Unfortunately, 20 years later, this mainframe computer system continues to be the mainstay fraud and abuse tool for most states. In an age where technological obsolescence is measured in days, our 20-year old systems are definitely the dinosaurs of technology. But then, as some states have reported, enhancing software technology to identify more cases without addressing proper staffing requirements simply results in more cases pending review.

Yet, despite the fact that most of the units have not grown in proportion to the Medicaid Program and are limited to 1970's computer technology, they continue to be successful. In a current survey, 20 states have reported identifying over $200M of provider fraud, abuse, and waste in their respective Medicaid Program's in the last two years. Recipient cases have amounted to an additional $47M of saved or recovered funds. These cases cover a wide range of discrepancies from simple billing errors to major fraud schemes. Cases vary from the provider that billed Medicaid for lab cultures performed by using a cardboard box and a light bulb, to the multimillion dollar scams involving providers and clients buying and selling Medicaid ID numbers for the sole purpose of defrauding the Medicaid Program.

SURS Units are also involved in addressing recipient abuse of health care services and administer the Restriction or Lock-in Program which limits a client to one physician, one pharmacy, and one hospital. An abusive pattern may for example include visits to 15-20 physicians to get prescriptions that are filled at an equal number of pharmacies. One State reported a client that had 160 emergency room visits in one year. The client abused services to the point that she would call an ambulance from the harness racing track to get transported to the hospital. The hospital subsequently provided her with her taxi fare to her home. The restriction program has been successful in curbing recipient abuse, however, for clients under both Medicaid and Medicare the abuse cannot be addressed. Since Medicare has no comparable program these dual eligible clients continue to abuse health care services. One such client has approximately 10 physicians and is seen in emergency rooms from which she receives narcotic prescriptions that she eventually sells at high stakes bingo games. Medicare covers her physician and emergency room visits, but Medicaid pays the co-insurance, the transportation to the services, and the narcotics if they are not early re-fills (otherwise she pays for those out of pocket). A cooperative recipient utilization control program needs to be established between Medicaid and Medicare. This is an area in which we believe HCFA could provide needed assistance and guidance.

It is important to note that in the last several years, the relationship between HCFA and the SURS units has made tremendous advances. The adversarial relationship of only 5 to 6 years ago has been replaced with a partnership to address Medicaid fraud and abuse. But in the course of partnering towards a united goal, the basic SURS requirements that States need to comply with have been eliminated. Instead, the requirement now indicates that States need only perform the SURS function. This can be met by simply assigning to an employee the additional duty of reporting any suspicious claims to their supervisor. In effect the fraud and abuse activity becomes another task for the employee and the supervisor. A proper case review by qualified and dedicated staff is not necessary to meet the current guidelines.

The SURS and Program Integrity Units have been tremendously successful. But, if our success is to continue, the individual States need to make the same commitment to fighting fraud, abuse, and waste in the Medicaid Program as Congress did when it funded additional staffing for the Office of Inspector General and the Federal Bureau of Investigation. Many States continue to operate with under-staffed SURS and Program Integrity Units and most do not possess the technological tools to identify the sophisticated fraud schemes that are occurring throughout our healthcare system. Why are States reluctant to increase their participation in this area? I believe that the current federal guidelines specifying the minimal requirements fail to convey Congress' commitment on this issue.

The federal government has clearly indicated its commitment to fighting health care fraud, abuse, and waste in the Medicare Program and now it needs to make the same commitment to the Medicaid Program.

One of the first issues that needs to be addressed is the statute requiring States to reimburse the Federal Financial Participation (FFP) portion within 60 days of notifying a provider of an overpayment. This requirement basically penalizes states

that actively pursue the waste found in their programs. Since both the State and the Federal government share in the cost of the Medicaid program, should they not also share equally in the cost of reducing waste in the Program?

The second way to insure that fraud, abuse, and waste do not go undetected is to institute guidelines and requirements that specifically address the minimum standards for a compliant SURS function. These guidelines should address minimum staffing requirements, which could be based on Medicaid expenditures, and require sound technological tools. These new guidelines could also provide an incentive for States to expand their commitment by funding at a 75% match all state positions whose primary duties are directly associated with Medicaid fraud and abuse. In addition, creative methods of funding the acquisition of technological tools could further enhance the federal government's commitment to the States. As an example, the federal government could offer to initially fund 100% of new technology and allow states to repay their share through the recoveries from fraud and abuse.

The Surveillance and Utilization Review Units and Program Integrity Units share Congress' commitment in the fight against health care fraud, abuse, and waste. We believe that our units provide a solid foundation from which your commitment to effectively address these issues can become a reality. Again, thank you for this opportunity and I will be happy to answer any questions you may have.

Mr. UPTON. Thank you again very much.

Ms. Thompson.

## TESTIMONY OF PENNY THOMPSON

Ms. THOMPSON. Mr. Chairman, distinguished subcommittee members, thank you for the opportunity to discuss our efforts to fight fraud, waste and abuse in Medicaid.

I'm accompanied by Rhonda Hall, who is the National Coordinator of our fight against fraud and abuse in Medicaid, leading the HCFA team which works day to day with our Technical Advisory Group on this issue.

We share your concern for protecting taxpayer dollars and Medicaid program integrity, and we appreciate the evaluations and advice provided by the HHS Inspector General and the General Accounting Office on these efforts.

We fight fraud, waste and abuse in Medicaid in partnership with States, beneficiaries, providers, contractors and other Federal agencies. States are primarily responsible for finding, prosecuting and preventing Medicaid fraud. We provide funding, technical assistance, and oversight. Ms. Williams, in particular, talked about some of our activities in regard to this in her testimony.

Some States are making good progress in making sure their Medicaid programs protect taxpayer dollars. However, we all agree that more needs to be done.

To further our efforts, we hired an expert outside contractor, Dr. Malcolm Sparrow, to lead four seminars with State agencies and produce a report on how to better fight Medicaid fraud. His report has three key findings for us.

First, we need to do more to address problems in managed care. States want more guidance and more help in identifying and pursuing fraud in the managed care environment.

Second, we need to help States develop better data systems for finding fraud. States are looking for more assistance and more guidance and more support in pursuing technological solutions in addressing fraud.

And, finally, we need to make sure that all the States are taking the issue seriously.

And I have to say about this, if you had asked me to predict before we began these seminars what the key findings would be, I would have predicted that States would be looking for assistance with technology, and I would have predicted that States would have been looking for assistance with pursuing fraud in managed care environments.

I would not have predicted that States would have reported that they still had a problem in getting their leadership, legislative and executive, to take this issue seriously. After all, the President has led us in an effort against fraud, waste and abuse in our health care programs. The Secretary of Health and Human Services has established this as a top priority. The Attorney General has established health care fraud as a top priority. The Congress has been active in holding hearings and pursuing legislation on health care fraud. I would have thought that we were past the point of needing to ensure that people were taking this issue seriously.

We are taking several steps to help States. We are providing guidance on how to address the unique program integrity issues related to managed care and are finishing up work on a document to be released to States to make suggestions to them about what to look for in managed care environments and how to pursue those kinds of issues. We are helping States to develop better data systems and other technological tools. Our technology conference being planned for next year will build on a comprehensive catalog we are developing of anti-fraud technology solutions. We are providing guidance and technical assistance so States can strengthen efforts to prevent improper payments, rather than trying to recoup them after the fact. And we are helping States share best practices and legislative strategies for fighting fraud.

These actions are helping to build a foundation upon which we, together with the States, establish measurable goals for improvement and greater accountability. This is essential, because clearly each State must be held accountable for protecting taxpayer dollars and in making measurable improvement in fighting fraud, waste and abuse.

In the coming months, we will begin working with States to develop systems to measure their progress in fighting fraud. Early next year, we will be sending a national review team out to a targeted selection of States to look at their anti-fraud efforts. We will test a new review protocol, and we will hold a commitment conference composed of senior State and Federal officials to obtain agreements about goals, expectations, resources, measures and accountability.

We welcome your assistance and appreciate your continued interests in these efforts. Thank you for holding this hearing, and I'm happy to answer any questions.

[The prepared statement of Penny Thompson follows:]

PREPARED STATEMENT OF PENNY THOMPSON, PROGRAM INTEGRITY DIRECTOR AND RHONDA HALL, MEDICAID FRAUD & ABUSE NATIONAL COORDINATOR, HEALTH CARE FINANCING ADMINISTRATION

Chairman Bliley, Chairman Upton, Representative Klink, distinguished Subcommittee members, thank you for the opportunity to discuss our efforts to fight fraud, waste, and abuse in Medicaid. We share your concern for protecting taxpayer dollars and Medicaid program integrity. And we appreciate the evaluations and ad-

vice provided by the HHS Inspector General and the General Accounting Office on these efforts.

We fight fraud, waste, and abuse in Medicaid in partnership with States, beneficiaries, providers, contractors, and federal agencies. States are primarily responsible for detecting, prosecuting, and preventing Medicaid fraud, waste, and abuse. We provide funding and technical assistance and oversee States in their efforts to ensure that taxpayer dollars are spent appropriately.

Some States are making good progress in making sure that their Medicaid programs protect taxpayer dollars. However, we all agree that more needs to be done, and we are committed to repeating and building upon this success across the country.

To further these efforts, we hired an expert outside contractor, Dr. Malcolm Sparrow, to conduct seminars and produce a report on how to better fight Medicaid fraud, waste, and abuse.

We are providing States with comprehensive guidance and technical assistance so they can build strengthen efforts to prevent improper payments, rather than try to recoup them after the fact.

We also are working with States to help them develop better data systems and other technological tools for ferreting out fraud, waste, and abuse. And we are modifying our National Fraud Investigation Database to include Medicaid cases, which will further help in tracking down and stopping unscrupulous providers across the country.

These actions are helping to build a foundation upon which we can, together with States, establish measurable goals for improvement and greater accountability. In the coming months, we will begin working with States to develop systems to measure their progress in fighting fraud, waste, and abuse. Two states have already begun developing claims error rates to accurately determine the extent of improper payments. Concrete goals and accountability measures will provide a clearer picture of what we must do to eliminate fraud, waste, and abuse in Medicaid and ensure that taxpayer dollars are spent appropriately.

## BACKGROUND

Medicaid is a State/federal partnership. Each State runs its own program with federal financial support and oversight. Beyond a core set of mandatory covered services, Medicaid programs vary widely among States. Each State Medicaid program is required to have systems in place to protect program integrity but, again, these vary widely. Some states have independent Inspectors General, others have very active involvement from the Office of the Controller, and others rely heavily on the State Attorney General.

Special federal matching funds are available for State Medicaid fraud control units. These fraud control units are usually located in the State Attorney General's office and generally perform both investigatory and prosecutorial functions. Congress specifically prohibited these units from being part of the designated Medicaid agency to assure investigative independence. Forty-seven States have established such units to investigate allegations. The HHS Inspector General administers the funding and activities of these State Medicaid fraud units. In States without fraud control units, the Medicaid agency is responsible for investigating allegations and referring cases to the appropriate authorities.

Federal funding is also available to States for Medicaid management information systems. All States include review of claims before they are paid, as well as surveillance and utilization review to look for errors after claims are paid, in their management information systems. The prepayment reviews include verification that the recipient is an eligible beneficiary, the provider is authorized to furnish services, the services and visits are logically consistent, the payment does not exceed the reimbursement rate, and that no other party is legally liable for payment. The post-payment reviews identify abnormal billing patterns that may indicate fraud, waste, or abuse. The surveillance and utilization review units are required to refer suspected fraud to the fraud control units, if one exists, for further investigation and possible prosecution.

*Federal Oversight*

In June 1997, our agency's Southern Consortium was given the lead for the national Medicaid fraud and abuse oversight efforts. The Southern Consortium, which consists of the Atlanta and Dallas regional offices, had already been very aggressive in tackling some of the most daunting program integrity challenges. The Consortium's leadership and this innovative arrangement allows our national office to get closer to the "front lines" of State activity in the fight against fraud, waste, and abuse.

In August 1997, we convened a focus group of State Medicaid staff to assess States' efforts, needs, and challenges. This provided many valuable lessons that we have been able to act upon.

For example, one of the major needs expressed by the States was for a national forum that States can use to share information and discuss issues. We therefore formed the Medicaid Fraud and Abuse Control Technical Advisory Group in which State and federal technical staff discuss how program integrity policy is carried out. This advisory group is divided into six workgroups, including:

- the Legislative and Regulatory Workgroup, which is charged with developing State legislative proposals and policy clarification on a number of issues;
- the Database Workgroup, which is developing an educational packet that identifies various reporting requirements and suggestions on how States can implement them;
- the Pharmacy Workgroup, which is formulating a Best Practices guide for controlling fraud and abuse in the pharmacy area;
- the Inspector General's Issues Workgroup, which is identifying various Inspector General activities that affect states and collaborating with the Inspector General to allow State input into the design and development of audits, studies, etc.;
- the Managed Care Workgroup, which is focusing on operational issues related to the unique program integrity problems posed by managed care; and
- the Data Sharing Workgroup, which is will disseminate information to all States on Medicare-Medicaid data sharing rules.

The advisory group has also surveyed program integrity and fraud control unit officials across the country to gain a deeper understanding of their needs and concerns.

## FRAUD AND ABUSE SEMINARS

Because of the clear need to be more effective in fighting Medicaid fraud, waste, and abuse, we last year contracted with Dr. Malcolm Sparrow, a nationally recognized expert in health care fraud issues. He conducted a series of seminars across the country where State program integrity personnel came together to discuss their successes, challenges, and concerns. Three essential themes emerged:

- *There are unique program integrity issues within managed care that need to be addressed.* Many States are still learning how to address the unique program integrity challenges posed by managed care, and some are fighting the misconception that managed care somehow does away with program integrity issues.
- *There are substantial technology issues, such as obtaining access to claims databases, claims analysis, fraud & abuse detection.* Many States have inadequate technological infrastructures and a basic inability to interrogate databases efficiently to ferret out improper claims. They could benefit from further guidance and technical assistance on acquiring new data systems and other fraud and abuse detection tools.
- *There is a need for building commitment, understanding, support, and resources for fraud and abuse control efforts.* While some States are having success, the seminars made clear that, in many States, the nature and magnitude of the Medicaid fraud problem is still not properly understood. In some States it may not even be treated as a serious or central issue in program administration.

We are taking several steps to help States address these concerns.

## MANAGED CARE

For managed care, we have sponsored a series of workshops, dating back to 1997, to bring State managed care staff together with utilization and review directors and fraud control unit directors. They have been conducted in conjunction with George Washington University's Center for Health Policy Research and attended by Medicaid staff from 49 States. These workshops focused on how fraud manifests differently within the managed care setting and how programs to address it should be structured. They also featured "negotiating sessions" among State delegations and resulted in written agreements on how to work more cooperatively and effectively together.

To further address managed care program integrity issues, we worked with State Medicaid agencies and fraud control units to develop *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care.* The guidelines focus on:

- key components of an effective managed care fraud control program ;
- data needed to detect and prosecute managed care fraud;

- how to report managed care fraud,
- suggested language for managed care contracts and waivers to help fight and prevent program integrity problems; and
- the roles of the Health Care Financing Administration, State Medicaid agencies, State fraud control units, managed care organizations, and the HHS Inspector General.

We hope to have these guidelines to the States by early next year.

TECHNOLOGY AND DATA SYSTEMS

Better data systems are key to improving efforts to fight Medicaid fraud, waste, and abuse. We are working diligently to help States make the most effective use of State and federal data systems and data collection efforts. As noted above, our technical advisory group is preparing an educational packet that identifies various reporting requirements and suggestions for how States can implement them. They are also compiling and will disseminate information to all States on Medicare-Medicaid data sharing rules.

We recently developed a national fraud and abuse electronic bulletin board, cosponsored by the American Public Human Services Association, to allow States to exchange and share information on fraud and abuse related issues.

These efforts are particularly important because instances of fraud and abuse are often not limited to one State or even one program. For example, a special South Florida task force demonstration project had unprecedented success in fighting fraud, waste and abuse by getting Medicaid agencies, Medicaid fraud control units, Medicare claims processing contractors, and U.S. Attorneys to all work together to detect fraud and abuse in both Medicare and Medicaid. For example, the task force matched Medicare and Medicaid data to identify patterns of questionable billing practices. We have learned from this effort and are encouraging other States to replicate these types of efforts.

And, as mentioned above, we are modifying our National Fraud Investigation Database to include Medicaid cases. Until now, this system has captured only Medicare information. This will play a key role in helping us to replicate the success seen in the South Florida task force demonstration project.

STATE ACCOUNTABILITY

Because States have the primary responsibility for protecting Medicaid program integrity, we are taking several steps to help States meet this challenge and understand their obligation to ensure that taxpayer dollars are spent appropriately.

For example, we have developed and posted on our www.hcfa.gov website a comprehensive listing of State statutes that target Medicaid fraud. This allows States to access and share innovative and effective program integrity legislation. For example, if a State is considering proposing legislation to regulate third party liability, a listing of State laws on this subject is readily available, along with links that allow direct viewing of statutory language. The website also includes detailed contact information for State program integrity personnel and individual State legislation web sites.

And we are now working to clarify how States can ensure that payments are not made to providers who have been "excluded" from Medicare and Medicaid because of program integrity or other problems. We have worked closely with the HHS Office of the Inspector General on this, and expect to disseminate clear guidance on the process early next year. This guidance will address the specifics of what must be reported to whom, when and where, as well as how to enforce exclusions, and the consequences for States that fail to comply. We are also working to help States enhance their processes for identifying excluded providers.

Still, it is clear that each State needs to be held accountable for protecting taxpayer dollars and meeting concrete goals and objectives for improvement in the fight against fraud, waste, and abuse. As mentioned above, we are going to work with States to develop systems to measure their progress. Two states have already begun developing claims error rates that are essential for accurately determining the extent of improper payments and any improvement in preventing them. With clear goals and concrete accountability measures we will have a clearer picture of what we must do to further to eliminate fraud, waste, and abuse from Medicaid.

Internally, we have developed clear guidance for our own staff on how to review State agency program integrity efforts, both in fee-for-service and managed care. This guidance mandates focus on:

- how States identify, receive, process and use information regarding potential fraud and abuse by Medicaid providers;

- how entities outside the Medicaid agency participate in preventing, identifying and reducing fraud and abuse;
- whether key program integrity components are included in State contracts with managed care organizations; and
- whether State agencies are complying with appropriate laws and regulations.

To begin developing objective and measurable goals for improvement, we will in January 2000 send a national review team to conduct a targeted evaluation of anti-fraud efforts in eight States selected to represent a cross section of State Medicaid programs. This will help provide an accurate assessment of where States are, what barriers may hinder their progress, and what most needs to be done to ensure substantial, measurable improvement.

CONCLUSION

We have been working diligently to help States improve their efforts to fight Medicaid fraud, waste, and abuse. We are providing States with information, tools and training to build effective program integrity infrastructures. And we are building a basis for holding States accountable for measurable improvement in their program integrity efforts. We welcome your assistance and appreciate your continued interest. And I am happy to answer your questions.

Mr. UPTON. Thank you all very much.

I just know, before my 5 minutes starts, you talk about MFCUs, I used to follow a running back from Michigan by the name of Tim Biakabutuka, he plays for Carolina now.

Mr. BURR. North Carolina.

Mr. UPTON. Don't ask me to spell it.

We're going to start with members asking 5 minutes of questions, and we will rotate.

Ms. Aronovitz, as I read your testimony last night—and I want to thank all of the witnesses who provided their testimony last night. HCFA was close. I walked out the door at 6 to vote, and I think it showed up to 5 to 6, so I was able to take it with me.

As I read this, particularly this specific instance in Tennessee where a managed care plan used a homeless shelter for the address of nearly 4,500 fictitious enrollees, how easy was it to find examples like that in the report that you found?

Ms. ARONOVITZ. It's not that difficult at all. The States all do have their horror stories, and actually the flip side of that is their successes in being able to identify those situations. I think they would all say that they need to do more, invest in more technology, better technology, and have more resources.

I think that was something that we've heard even in the little amount of work we've done since we started our study, that States really are looking for more resources and better technology and more sophisticated approaches to identifying those types of problems.

Mr. UPTON. Would you say—in my opening statement, I talked about 10 percent fraud and abuse, which is $17 billion. Is that about what you think? Is that a pretty accurate figure? Do you think it's more than that? Do you think it's less—if you had to say.

Ms. ARONOVITZ. It's very—it's literally impossible to tell. But I do want to make a differentiation between improper payments and fraud. Fraud is the intentional wrongdoing, which needs to be proved. So when you talk about any number, any estimate, you're talking about payments that should not have been made for one reason or another. Until a case is actually taken through the system and prosecuted, you can't really say whether it was fraudulent or not. So, therefore, fraud is particularly hard to measure.

Mr. UPTON. Mr. Fecteau, yesterday I spent an hour with my local hospital board and a number of other providers and the last couple of weeks as well. We were hoping to take some legislation up tomorrow to remedy some of the Balanced Budget Act of 1997 reductions to providers, and we're looking at about a $13 billion package over 5 years, and we're trying to figure out the ways we can pay for it as well.

As we think about the 10 percent—you know, sort of the lay of the land 10 percent fraud figure, $17 billion, I mean, does that come and fulfill the dream that a lot of our providers would wish for? And you talked about the $240 million in fraud and abuse that your organization has sort of looked at, but that's over 2 years. I mean, that's only scratching the surface of what might be out there.

Mr. FECTEAU. That's correct.

Mr. UPTON. I mean, that's pretty incredible that—I mean, even though we identified perhaps as much as $17 billion a year, $34 billion over 2 years, in fact, our collection efforts are pretty—identification methods are pretty miserable?

Mr. FECTEAU. Again, that's 20 States, and again the SURS units in some of the larger States, the units and program integrity units are broken into various subunits. And this does not—I know one State, Texas, the reports that I got in from them was not totally complete, based on what HCFA's figures were.

But you are right. The methods in most States for identifying fraud, abuse and waste are antiquated systems at this time.

Mr. UPTON. Okay. Ms. Williams, I very much appreciated reading your testimony last night. And, in fact, I focused on I guess the—early on in your testimony you talk about the fleeing felons. Another issue that would require legislation is that of fleeing felons, welfare reform legislation specifically including Medicare provisions that make felons ineligible to receive government benefits.

I actually had that amendment passed in this committee when we dealt with this subject about 2 years ago, and the Senate dropped it in conference. And I certainly—based on the hearing today and other hearings that we had, I also serve on the Health and Environment Subcommittee, and I would like to work with Chairman Bilirakis to develop legislation that will give everyone the tools to identify the abuses that are out there and to really go after the people that abuse the system in a major way.

And I particularly appreciated your number of examples of what we can do. When you talked about the 60-day rule, do you have—and you made a very good point, for all of us that pay income taxes—do you think we ought to just discard that altogether? Should we have a day limit, 120 days, 180 days, or should we just say when the money is collected, that's when you pay it back?

Ms. WILLIAMS. I think definitely when the money is collected it should be—the Federal financial participation should be immediately refunded. I think there can be standards set on a State for reasonable collection activities. I think that there is room for some constructive definition of what reasonable collection activities are, but to have to refund the Federal matching before a State has the opportunity to collect the funds, particularly if they're in a process

of negotiating plea bargain agreements, that sort of thing, it's very, very punitive on the States.

I think there's somewhere in between that we can go besides totally forgetting the money until it's collected. I think there's some reasonable standards of promptness that can be agreed upon that would be reasonable for the States to collect or pursue collection, but to have to refund the money in advance is extremely punitive.

Mr. UPTON. I know my time is expired. But I just wish to really thank you for your testimony, and we can work together.

And maybe just a quick comment from Ms. Thompson. Do you all have any comments in terms—it would be nice to have the legislation—the administration onboard with a package like this and really make it bipartisan and save the taxpayers some money. I don't know if you've commented publicly in terms of some of the items that the States have offered up.

Ms. THOMPSON. Let me comment specifically on the 60-day rule, because the administration has said that it does not support eliminating the 60-day rule. But I think the kinds of comments that Ms. Williams talked about in terms of finding some reasonable accommodation in the middle I think makes a lot of sense.

What we don't want to do is find ourselves in a situation where we don't have any kind of standard or any kind of assurance that collections are going to be made. In fact, the large majority of overpayments are, in fact, administrative overpayments, and it's a debt collection matter, and we certainly want to encourage States to be expeditious in handling those kinds of matters. At the same time, I think we're well aware of the kinds of problems that Ms. Williams cites, and we would be happy to explore further what some possible legislative solutions might be in that regard.

Mr. UPTON. Just a last question, what about suspending the card of folks who abuse Medicaid services.

Ms. THOMPSON. I have to say I'm not sure what the administration has said about that. But I think certainly one of the things that we would pursue is how to handle recipient collusion. I think that is a big issue, particularly in some of the organized crime and organized scams. Lock-in is also a potential available mechanism, for States to require beneficiaries to go to a particular pharmacy or a particular provider and control their utilization in this manner as well.

Mr. UPTON. Okay. Mr. Burr.

Mr. BURR. Ms. Williams, I want to thank you on behalf of Mr. Bryant and I for being a witness that we could understand. It's not very often that we have the opportunity with this group in Washington to get Southerners up here, and I appreciate that.

Ms. Aronovitz, let me ask you, can fraud control really exist without structural changes to the delivery system?

Ms. ARONOVITZ. Are you talking about the managed care structure and the fee-for-service structure?

Mr. BURR. Just talking about Medicaid as it's currently designed, whether it's the regulations that come from HCFA or what the States design. Without changes, can we have fraud control that we feel confident works?

Ms. ARONOVITZ. That question is one that we haven't really looked into in any great depth. It's quite broad and very important.

Mr. BURR. Isn't it important, though?

Ms. ARONOVITZ. Absolutely. It's a policy, programmatic question that needs to be addressed; and one way to start would be to look at specific activities of the program integrity units in the State Medicaid agencies.

Mr. BURR. With I think the exception of Ms. Williams, I heard everybody convince me and I think convince everybody in this room that waste, fraud and abuse exists in Medicaid. So let's not go back over that part. Let's start there and say, now how do we solve it?

And I guess my question is very simple. Do you, as one who has looked at the problem, believe that you can solve the problem without structural changes?

Ms. ARONOVITZ. I think that any large health care program will be vulnerable. There are a lot of reasons why Medicaid and Medicare, in particular, would be vulnerable in any structure. It has to do with the fact that in Medicaid, in particular, you're running 50 different programs where claims that are coming in are a very small value each, but it's the volume of the claims that ends up being a problem.

Mr. BURR. Can we agree that there is going to continue to be, regardless of how creative we get and how vigilant we are with waste, fraud and abuse teams or reports or reviews, waste, fraud and abuse?

Ms. ARONOVITZ. This program will always be vulnerable, yes, in my opinion.

Mr. BURR. Mr. Hartwig, you've looked at waste, fraud and abuse before, haven't you?

Mr. HARTWIG. Yes.

Mr. BURR. Tell me what has changed structurally since the last time you looked at it and this time you looked at it.

Mr. HARTWIG. Let me just make a general comment first. And you raised the issue about the health care system. The health care system is basically a voluntary payment system. It's a system based on trust, so I think you're always going to have some abuses of that system. To handle those abuses, health care is a chain, and the chain starts with the recipient and beneficiaries, and it goes up to law enforcement.

Mr. BURR. Tell me what has changed in that since the last time you looked at it.

Mr. HARTWIG. I am getting to the change. There's certainly a lot more awareness today than in the past about fraud and abuse in the health care system. I think some work that our office did on the review of the financial statements of the Medicare program; I think Operation Restore Trust, an initiative that was started by the Department of Health and Human Services a number of years ago as a partnership effort involving both Federal, State and local law enforcement; and I think some of the recent initiatives of making health care fraud a priority have changed the system, because of how we looked at it.

Mr. BURR. Tell me how the system differs, if you take law enforcement changes out of the mix.

Mr. HARTWIG. I think there's a greater awareness today than in the past of a system being abused. I don't know that there's been

fundamental changes in the way that the system pays claims and the way the system has been abused or allows itself to be abused.

Mr. BURR. Let me ask Mr. Krayniak. You said that we have caught—we have prosecuted Medicaid fraud and abuse. Why does it still exist?

Mr. KRAYNIAK. The Medicaid Fraud Control Units are really at the end of the chain Mr. Hartwig just described. We get the referrals from the single State agency or from whatever agency, and our response is limited. I mean, we are prosecutors, we can go into court, we can seek incarceration, fines and other appropriate penalties. That certainly serves the deterrent effect. But we are, as I said, at the end of that line, and the numbers of cases that we are able to bring to successful conclusion, while it does serve a deterrent effect, certainly cannot change the structure of the system.

Mr. BURR. Do you think that people are aware of the waste, fraud and abuse that exists out there?

Mr. KRAYNIAK. I've been the director in our State for 6 years; and I can say, in that time, the awareness, the attention and the resources that have been paid to it have increased very, very dramatically, so I would answer your question yes.

Mr. BURR. Ms. Williams, let me commend you and the Technical Advisory Group, because I think you did mention some things that I hope people wrote down. You talked about S-CHIP, which is the children's program. And I want to ask you, how did we provide for flexibility in that that's not provided for in the normal Medicaid program where it makes it easier to make sure that there's less waste, fraud and abuse in the children's program than in the normal Medicaid?

Ms. WILLIAMS. Please understand my reference to the S-CHIP program was not related directly to fraud and abuse. My reference to the S-CHIP program was how Congress identified an urgent need, wanted States to react quickly and effectively and provided two major incentives to make that happen, financial incentive and increased matching and flexibility and program design to let the States tailor the program to meet their needs.

I know in Alabama, when S-CHIP was passed, it received huge attention by the Alabama legislature and the administration to act quickly to take advantage of this encouragement from Congress to address this problem, a problem that, a year before, I'm not sure the Alabama legislature really understood existed.

Mr. BURR. But a plan can be designed in a way that creates less of an incentive for waste, fraud and abuse.

Ms. WILLIAMS. Absolutely. What I believe was accomplished with the S-CHIP legislation in terms of a model is Congress decided and defined what it wanted out of the program in very clear terms. There were standards set that States had to comply with, and then money was put with that.

There was flexibility on how States achieved that goal of ensuring children and how the programs were designed for their States, whether it was private insurance, expanded Medicaid, a variety of solutions, but the ultimate goal was defined very clearly by Congress, and then the money came with it.

I believe that Congress could do the same with Medicaid fraud and abuse, define the end results that Congress wishes to see occur

in State Medicaid programs and then incentivize States with the flexibility to meet that goal and enhance Federal matching funds above the current 50/50 match to do it.

Mr. BURR. You just hit on a tremendous key, and I just want to make sure everybody heard you. You said incentivize our ability to make the system better. I think we work in a penalty system in most cases, and that does not achieve a better system, I can assure you.

Let me move to Ms. Thompson just very quickly, because I know my time has run out, Mr. Chairman.

Ms. Thompson, tell me what HCFA's success is with fraudulent Medicare recovered dollars. Is it 100 percent?

Ms. THOMPSON. No.

Mr. BURR. It's not, is it? It's a fairly low number, if I remember. I can't quote it right off the top of my head, but I think we looked at that before.

My only point for raising that question is for you to take back to HCFA and to the administration that, we cannot expect the State recovery on fraudulent Medicaid to be 100 percent, yet we take an inflexible position as it relates to their reimbursement of us once they identify and report overpayment or fraudulent payments, and I think that that's something that this Congress and this administration needs to address.

Let me just make one last statement as it relates to your testimony. And I hope that HCFA—and I feel confident that they will work with Congress to make sure that we provide whatever tools and allow whatever flexibility for States to change their programs to create incentives for the elimination of waste, fraud and abuse and to suggest to HCFA, in a number of places you refer to objectives under way, objectives to measure goals to assess the need for improvement and national review teams. We're passed that. We don't need to review it anymore. We know there's a problem. What we need to do is sit down and find the solution.

And if the solution is third-party people being hired by States to come in and pay claims and—you know, I raise the question, because I know we're going to hear from some third-party folk—then some States might have to adopt that, if they can't run the programs efficiently their own way.

But I think we need to get past trying to determine whether there's a problem, admit there is a problem, and find the solution.

I thank the chairman for his indulgence. I yield back.

Mr. UPTON. Mr. Bryant.

Mr. BRYANT. Thank you, Mr. Chairman.

Let me first say that I'm going to have to leave here very shortly and go to another very important meeting and will try to get back probably for the second panel, as soon as I can. But I have a number of points I wanted to make, and I wanted to thank this panel for being helpful in your testimony.

I think the title of this hearing is Medicaid Fraud and Abuse. I think there's another element out there that we're not really discussing that we waste, and it's something that does not get into the element of fraud and something—a distinction I think we have to be careful—particularly I know we will hear from the second panel about differentiating between those three issues.

I understand today's hearing mainly concerns fraud and particularly the organized—one part of today's hearing, the organized crime, criminal element of health care fraud. And that's the one that I'm particularly concerned about and think we ought to come down the hardest on, because typically I would think that's the largest amount that we're talking about.

One nice thing about health care fraud from—a silver lining in a cloud, there's a lot of times there's money you can recover, unlike a lot of crime out there. You catch the crook and put him in jail, and that's about all you can do. In this, there's money that can be recovered.

And I know several of you testified as to the amounts of money that you picked up and added back to Treasury, but I think—of course, that's a drop in the bucket, but we do have that opportunity. And if there's any way that we can as a Congress enhance that ability—and I think back to things like asset forfeiture that we use so appropriately in drug cases, at least I think it's appropriate, and that's sort of an issue of argument now in this Congress. But if we might look at that.

And I will be honest with you. I don't know—it may take an expansion of the law to get into this type of area. Here again, distinguishing very carefully between the waste and maybe perhaps some abuse, some confusion, but highlighting those fraudulent cases, particularly the bigger cases out there that we could go out hopefully and not harass people who make honest and legitimate mistakes.

One question I throw out, Ms. Williams—and again I'm doing a lot of talking. I've got, really, one question I want to ask Mr. Hartwig at the end. But, Ms. Williams, and maybe this is done, but in reviewing the GAO report, there are all kinds of scenarios where this type of crime is committed. Some of it has to do with the mailbox, drop box, that kind of stuff. Do we have the ability to administratively pay only—have a ruling that we're only going to pay people with addresses and we're not going to send checks to mailboxes and drop boxes and things like that? Can we do that? Is that a possibility?

Ms. WILLIAMS. It is a possibility. It presents new issues. For example, out-of-State providers, how do they properly get certified? Do we send State enrollment, provider enrollment staff around the country verifying the out-of-State providers? Alabama for years prohibited out-of-State providers except for emergency situations; and, unfortunately, the courts decided that was inappropriate, that we had to let any provider that wanted to participate in Alabama, regardless of where they were from, participate. I think there are some issues like that.

I know Florida has been very successful in certain provider types that seem to have a higher vulnerability to fraud, such as durable medical equipment providers that, prior to enrollment, they are making a physical site visit to make sure it's not a drop box, to make sure there is an actual business. So, yes, sir, there are things like that that States are already doing in their enrollment process to try to identify providers beforehand.

Mr. BRYANT. Okay. You know, sitting up here you think of all of these ideas and you realize this is not the first time, in all prob-

ability, that a light was going off, so there's a lot of smart people out there trying to think about this, too.

Mr. Hartwig, let me ask you about the GAO report last week that was made to Senator Collins which described the influence of organized crime in committing Medicaid fraud. I know it is difficult to investigate and try these cases, but this is maybe something you can answer. And my time is running out, but if you can answer today and then maybe follow up with a more comprehensive written response to these questions.

What steps is OIG taking to assist State Medicaid and law enforcement officials in their efforts to combat this problem of, again, organized crime involved in Medicaid fraud? And can you specifically detail what efforts OIG has made to identify these criminal groups that are targeting multiple State Medicaid programs? What efforts are being made to improve provider enrollment controls to keep fraudulent providers out? And what additional resources is OIG making available to the State investigators and prosecutors to assist them in their efforts to combat this problem?

And given the serious nature of this and sort of the feeling that some of us have here, and I know you all are just as frustrated, but maybe to keep some accountability here, I would ask that you, OIG, keep this committee informed on its efforts to crack down on these criminal groups that I'm talking about, again organized type, larger groups, which are defrauding Medicaid. And with the Chairman's permission, I would like to ask that OIG submit reports maybe on a quarterly basis to this committee and keep us up on your efforts and help us maybe relieve some of the frustrations. Does that sound reasonable?

Mr. HARTWIG. It certainly sounds reasonable.

I will tell you that one of the methods that we use is local task forces and national task forces as a way of identifying organized groups. And a second problem we have is certainly large providers that operate in 30 or 40 States, in identifying those. And Mr. Krayniak mentioned being a part of the negotiating team to negotiate some global settlements.

I mentioned the National Health Care Task Force as a way of looking at State, local and Federal enforcement issues on these organized groups that not only target single States. They target multiple States; they target the Medicaid program; they target private insurance programs. And one of the things that we have found is they are very good at finding in which State, in which contractors on the Federal level, and in what State contractors, there's a weakness, then going through and targeting that.

We also in the OIG have issued what we call fraud alerts. Those are items where we have found examples or groups that may be operating—targeting a single procedure code, or targeting single procedures, and looking at identifying that, letting people know, and educating other law enforcement agencies.

One of the areas that we have partnership with the States a lot is our exclusion program. The Inspector General has the authority to exclude providers from participating in federally funded State programs.

We currently have 15,000 providers on that exclusion list. The Medicaid Fraud Control Units supply about a quarter of the people

that are on those lists through their convictions. State licensing boards supply about 40 percent. I think it's very important as we look to control Medicare fraud and Medicaid fraud not to let those individuals come into the program in the first place.

We've heard about recipient fraud—and I will just speak briefly. You know, we have found that both recipients and beneficiaries can be the hub of a fraud program. We have a fairly substantial case involving Medicaid and Medicare clinics where we have identified beneficiaries and recipients who actually sell their cards or give their cards away. We had identified 3,000 of those beneficiaries in a single State. We looked at the top 10 beneficiaries, and in less than 2 years their numbers had been billed over $100,000 in durable medical equipment alone. We and the Health Care Financing Administration took steps to stop paying claims for those beneficiaries, and we didn't hear a single complaint.

So we are working with State authorities in that area to expand where we have identified beneficiaries who allow their numbers to be used. Again, as I look at the chain, we not only look at the organized groups but we also look at the total chain that allows them to operate, starting with the recipients and beneficiaries.

Mr. BRYANT. Thank you. If you could just make that report to the directly to the committee staff.

I will close by simply saying that you sound like you're doing an awful lot of things to identify ways to deter people. And I think if you look at the GAO report and you see the various ways that the system can be defrauded, which again they're just as ingenious as criminals can be and it always seems like one step ahead of us, but maybe get the major ways to do this and find the ways, whether it is through licensing or asset forfeiture of some sort or exclusion from the program, things that you are already doing that might affect people like insurance companies better, people like medical professionals better and somehow the victims and the recipients, I should say, who aren't victims, but the criminal recipients—I don't know how you best deter those folks, but that type of study.

And it sounds like you're making good progress there. But I think I alluded to the fact that the system is just so big, and we're—you know, we put a lot of money in all of this, but we're just underfunded, our prosecutors, our courts our prisons, and all of these things come into play, and I understand it's a big problem. But we just need to keep working together as best as we can. And, again, to relieve some of our frustrations, I appreciate the willingness of OIG to come forward with this information at this level.

I'm going to have to excuse myself, because I have to be there, but I will try and get back. Thank you.

Mr. UPTON. Thank you, Mr. Bryant.

I've got a couple more questions before we move on, and I know Mr. Burr is going to be coming back as well.

Mr. Krayniak, you are here for a number of reasons. One is, the New Jersey program has had a pretty good, nationally known reputation for your work exposing both managed care as well as pharmacy benefit problems. Tell us what are some of the things that New Jersey has done that maybe some other States haven't.

Mr. KRAYNIAK. One of the things we try to do is to work very closely with our single State agency. We meet with program integ-

rity people on a monthly basis. It's a formal case screening meeting.

Mr. UPTON. You go out and you physically inspect some of the, as we've heard about, mail drop boxes—I mean, do you have a very aggressive unit going out to make sure they're physically located someplace and actually doing the things that they're saying they're doing?

Mr. KRAYNIAK. We perform triage. As problems develop in one area, we focus on that area. We experienced the same situation, shell corporations with post office boxes, mailbox rentals. We send our investigators out, and we determine which providers are there. We attempt to contact those providers, either in person or by letter, telling them we're going to suspend payments until you come in.

We do that in conjunction with our single State agency. We've had no one come in as a result of those letters. No one has contested millions of dollars of claims that we've suspended because of work of my units done in identifying what we believe are fraudulent rings and referring it right back to the single State agency.

Mr. UPTON. Now, New Jersey, I have to believe is one of the members of the Technical Advisory Group that Ms. Williams serves; is that correct?

Ms. WILLIAMS. Yes, sir.

Mr. UPTON. How many other States do what New Jersey has done, Ms. Williams?

Ms. WILLIAMS. To——

Mr. UPTON. Or moving toward that end, I should say.

Ms. WILLIAMS. To some degree, I would think most of them—to some degree. What Mr. Krayniak described is a more formalized process. In Alabama we have a similar process where the Medicaid Fraud Control Unit and the State—single State agency's program integrity unit meet every month, go over pending cases, problems identified, how to expand on that. It varies from State to State.

There is a wide range of different relationships between the States, between the State Medicaid agencies and the control units. Some are very strong and cooperative, such as in New Jersey. Some are very hostile and competitive. So it's very difficult for me to say that every State—there's 47 Medicaid Fraud Control Units, I would say probably 47 relationships, but many States do try to do the same type of thing of having regular scheduled meetings between program integrity staff and fraud control unit staff to identify suspicious providers individually and global practices to try to come up with solutions to address them.

Mr. UPTON. Now, how long has the Technical Advisory Group been in existence?

Ms. WILLIAMS. The group had its first official organizational meeting in the spring of 1998, March, April. April, I believe, of 1998 was when it had its organizational meeting. So it's been in effect about 1½ years.

Mr. UPTON. Were you encouraged to do this by HCFA?

Ms. WILLIAMS. Yes.

Mr. UPTON. Or was it a self deal?

Ms. WILLIAMS. Yes, it was a cooperative decision between the National Association of State Medicaid Directors' Executive Committee, who meets with HCFA every quarter. It was brought to—

I believe HCFA actually brought the suggestion to the meeting and suggested that this Technical Advisory Group—but it was a joint decision of the two organizations to work together to create this Technical Advisory Group.

Mr. UPTON. And like some organizations, say the National Governors Council or the National Association of Counties, I mean, do you take stands on issues? Do you take a formal meeting where you adopt resolutions and encourage legislators to take a certain path?

Ms. WILLIAMS. The Technical Advisory Group, because it is an affiliate of the National Association of State Medicaid Directors, makes recommendations to that organization, as does the HCFA representatives to that Technical Advisory Group. The three pieces of legislation that I mentioned came from the TAG to the national association.

As an individual organization, no, sir, they do not take a national stance. The membership of this Technical Advisory Group is generally program and integrity directors within the States, with some representation from the Medicaid directors themselves and chaired by the Medicaid directors. So most of those staff people on that group are not comfortable in that environment. However, they feel very strongly about their recommendations and pass them on through the Medicaid Directors' Association.

Mr. UPTON. Ms. Thompson, throughout I think your testimony and other comments have been made, you all believe that the States indeed are on the front line of both identifying and then going after fraud and abuse. And it just seems to be, listening to the testimony from all different fronts, that is, the States are asking us to move forward to giving them more tools in a number of ways. But you all are not exactly 100 percent behind their efforts.

I mean, as I think about the collection efforts as an example, I remember that Congress a number years ago passed the Prompt Pay Bill, which required that the Federal Government be paid I think 30 days after something. And it would seem as though, with regard to payments back to States that if, in fact, they receive the money on January 1, that there would be some—that there could be some rule where they would actually reimburse the Federal Government by January 30 or, you know, 30 or 60 days versus the 60-day provision that is there now, which a very good example is used, it just is not working and it actually serves as a disincentive for the States to go after fraud and abuse, which in turn means something ought to be done.

Ms. THOMPSON. Well, as I mentioned before, first of all, let me say we're 100 percent behind all of the efforts to attack fraud and abuse. That doesn't mean that we're in 100 percent agreement on every particular on how to do that. And that's inevitable, and that's fine. As I mentioned, I think that we are certainly aware of some of the issues, for example, that Ms. Williams talks about in terms of the problems associated with the 60-day rule.

But the primary purpose behind that rule was to ensure that States were taking prompt action on debt collection matters. And so I think, as usual, we have to figure out how to balance some competing demands and priorities in a way that makes sense to everyone. And we would be happy to continue to have those conversa-

tions. What we don't support is just the elimination of that requirement without some other kind of structure or standard in place to make sure that the Federal Government is made whole in a timely fashion and that the States, in fact, have proper debt collection processes in place.

Mr. UPTON. I would just like to say, as I yield to Mr. Burr if he has additional questions, that I am going to talk to Chairman Bilirakis this afternoon and urge him to proceed in some way so that we can strengthen the hand to go after fraud and abuse. It's always a good line in any audience, I'm against fraud and abuse. I've only found one Member of Congress to vote against it when we've had that opportunity. But I do believe that we do—we have to provide more tools so that, in particular, we can go after the participants that in fact defraud the taxpayer of lots of money, way too much.

It's clearly a slippery slope that's only getting worse and not better, and we need to take advantage of some of the ideas, particularly from those on the front lines in terms of what they suggest that can strengthen their hand. And I know you will be a willing participant in that.

Ms. THOMPSON. Absolutely.

Mr. UPTON. And I intend to ask Mr. Bilirakis to move some legislation.

Mr. Burr, do you have any additional questions?

Mr. BURR. Only one comment, Mr. Chairman.

Ms. Thompson, please don't take this the wrong way. I don't think you hear Ms. Williams and some of the other State folks. What they're graciously offering is some good advice as to how more States would get committed to chasing waste, fraud and abuse, if there was not a punitive regulation on them to produce money prior to the collection of money. I would listen to her.

I think it's very wise advice. And I think that it's so wise that I think you may see legislative language which suggests that that is something that HCFA should adopt if they don't suggest it on their own.

I thank you. I yield back.

Mr. UPTON. Thank you very much for your testimony. We look forward to working with you in the days ahead, that's for sure. Have a terrific week.

We will call the second panel.

Mr. Mitchell Adams, who is the Chief Executive Officer of HealthWatch Technologies, Massachusetts; Mr. Greg Viola, Senior Manager of Deloitte and Touche, from New Jersey; Mr. Michael Glynn, CEO of the Codman Group, in Massachusetts; and Ms. Jean MacQuarrie from Medstat, from the great town of Ann Arbor, Michigan.

We need to get started. I am getting a little worried about votes. So we will—as you all heard, we have a long tradition of taking testimony under oath. Do any of you have objection to that? And under both House and committee rules, we allow you to have counsel, if you so desire and—do you have any desire to have counsel? Good.

If you would stand and raise your right hand.

[Witnesses sworn.]

Mr. UPTON. They're all now under oath.

Mr. Adams, if you're prepared, we will start with you.

**TESTIMONY OF MITCHELL ADAMS, CHIEF EXECUTIVE OFFICER, HEALTHWATCH, TECHNOLOGIES, LLC, ACCOMPANIED BY JIM GORMAN, PRESIDENT AND CHIEF OPERATING OFFICER; GREG VIOLA, SENIOR MANAGER, DELOITTE AND TOUCHE; MICHAEL J. GLYNN, CEO, CODMAN GROUP, ACCOMPANIED BY PHILIP CAPER, FOUNDER AND CHAIRMAN OF THE BOARD OF THE CODMAN GROUP; AND JEAN MACQUARRIE, MEDSTAT**

Mr. ADAMS. Good morning, Mr. Chairman and committee members. My name is Mitchell Adams. I'm Chief Executive Officer of HealthWatch Technologies, and HWT, LLC. Prior to my job, which I've had for about a year, I was for 8 years the Commissioner of Revenue of Massachusetts.

I'm joined this morning in the room with Jim Gorman, who is the President and Chief Operating Officer of our companies; and before this Jim was the Director of the Medicaid program in the State of Maine.

Our companies provide a unique and proven solution to the problem of Medicaid fraud and abuse, which combines proprietary systems, state-of-the-art information technologies, extensive Medicaid program experience and health care expertise. The team offers a full-spectrum service to States, including the specific identification of improper claims paid to providers and the collection of overpayments as an agent for the State.

The service, which includes all hardware, software, and personnel services, is offered on a contingent fee basis, determined as a percentage of the funds actually collected so that there is no costs to the State until recoveries are actually received. This approach meets an important need for States which generally do not have the personnel, financial resources, or IT expertise to address the problem.

The Commonwealth of Kentucky has demonstrated bold vision in undertaking what is believed to be the Nation's first full service identification and collection contract. The results have been extraordinary. Working closely with the Kentucky Department for Medicaid Services, the DMS, $30 million to $40 million of specific overpayments have been identified. Of this, $14 million is slated for collection action in the coming weeks; and it is expected that the balance, between $15 million and $25 million, will be collected in the coming months after final review by the DMS.

The project has resulted in the production of 160 results sets which include over 2 million lines of specific overpayments to providers. The hard copy printout comprises over 200,000 pages. Based on collection experience to date, it is estimated that approximately 80 percent of the overpayments identified will in fact be collected, returning up to $25 million to Kentucky.

While overpayments involve thousands of providers and include all categories of service providers, the data show that the abuse is concentrated among a very small percentage of providers, between 2 percent and 4 percent generally. The vast majority of Kentucky providers are honest, law-abiding citizens, playing by the rules.

Overpayments identified represent only a fraction of 1 percent of the paid claims analyzed.

Many studies assess the extent of overpayments in the system, as we've heard this morning, at about 10 percent. On the basis of these studies, it is estimated that the overpayments that could be identified in Kentucky, if this effort is continued, range between $600 million and $800 million.

Our team works closely with the Attorney General of Kentucky, the United States Attorneys for the Eastern and Western districts, Kentucky's Office of the Inspector General and representatives of the Federal Office of the OIG; and in the development of cases for criminal prosecution, these agencies have identified approximately 25 cases representing overpayments of over $1.5 million to review for possible criminal prosecution.

This approach can benefit the Medicaid system in two ways other than the recovery of funds. First, the algorithms that reveal the abuse that we have found can be converted into prepayment edits so that overpayments are not made in the future. Second, the action of collection will have a chilling effect on providers who are abusing the system, thus reducing improper claims prospectively.

We believe that the contingency recovery model described here and proven effective in Kentucky provides a workable solution to the problem of fraud and abuse in the Medicaid system and should be replicated in other States.

Presently we are aware of four other States that are following Kentucky's bold lead and are in the process of implementing this approach. HCFA needs to encourage States to adopt these innovative approaches to curbing health care fraud and abuse in the federally funded health care programs and generally. State agencies, which are generally understaffed and overworked, should be encouraged to use outside consultants whose main focus is the detection and prevention of Medicaid overpayments.

These consultants should not be involved with the payment of claims in the first instance and should be evaluated by HCFA and the States. HCFA should publish a list of approved consultants, as they have done with approved Medicare contractors. States should be encouraged by HCFA to pay these consultants on a contingent fee basis, as this method of payment provides the resources and incentive necessary to do the job.

Finally, we would respectfully request and recommend that this subcommittee continue to hold oversight hearings in order to monitor the progress HCFA and the States are making toward detecting and preventing the enormous amounts of overpayments that currently characterizes the Medicaid program. Without this continuing oversight, little progress is likely to be made.

Thank you very much for the privilege of presenting this testimony.

[The prepared statement of Mitchell Adams follows:]

PREPARED STATEMENT OF MITCHELL ADAMS, CEO, HEALTHWATCH TECHNOLOGIES, LLC

Mr. Chairman and Members of the Committee, good morning, my name is Mitchell Adams. I am here today representing HealthWatch Technologies, LLC, and HWT, LLC. Our team has done pioneering work in harnessing the power of informa-

tion technology to address the problem of fraud and abuse in the Medicaid System.[1] I have worked as the Chief Executive Officer of these companies for the last year. For the preceding eight years, from 1991 through 1998, I served as the Commissioner of Revenue of Massachusetts. In this agency we did ground breaking work in the application of the newest information technologies to the collection of state revenues and modernization of the State's Child Support Enforcement Program, which became a model program for the nation. Prior to becoming Commissioner of Revenue, I had 15 years experience in health systems management, as Vice Chancellor for Administration and Finance at the University of Massachusetts Medical Center, as Dean for Finance and Business at the Harvard Medical School and as Budget Director for Boston's Beth Israel Hospital. I presently serve as a member of the Board of Trustees of Harvard Vanguard Medical Associates, which constitutes the health centers division of Harvard Pilgrim Health Care, New England's largest HMO.

I am joined this morning by my colleague, Mr. James Gorman, who works with me in this innovative and challenging endeavor to combat Medicaid fraud. Before joining our team, Mr. Gorman was the Director of the Maine Bureau of Medical Services for five years, where he built a state-of-the-art data warehouse and decision support system for the state's Medicaid Program. Prior to joining the Bureau of Medical services, Mr. Gorman was a management expert assigned to the Department of Safeguards within the United Nations' International Atomic Energy Agency, the program charged with tracking the world's nuclear material.

First and foremost, I want to commend Commerce Committee Chairman Thomas J. Bliley for charging the General Accounting Office with the responsibility of conducting an in-depth survey to study and report on the current efforts to combat Medicaid fraud at various governmental levels. One of the specific charges to the GAO was to determine "innovative techniques and strategies" developed at the state level to be applied to fraud control efforts in other health care programs. HealthWatch Technologies, LLC, and HWT, LLC emphatically support this charge for the following reasons.

Multiple studies have demonstrated that the country's healthcare system is subject to extensive waste, fraud and abuse. Federal studies have shown that the extent of fraud and abuse in federally supported healthcare programs ranges from 10% to 14%. These studies show that the Medicaid program is undeniably a part of the problem. A comprehensive study in Texas recently found that a staggering 12.5% to 32.2% of Texas' Medicaid payments were questionable, depending on the type of service provided. Malcolm Sparrow, Professor of Practice at Harvard's Kennedy School of Government, and one of the nation's leading experts and researchers in the field of healthcare fraud and abuse, summarizes the situation this way; "Fraud in the healthcare system has been, and remains, *out of control.*"[2] Our experience in the field confirms Professor Sparrow's conclusion.

The problem exists in all the 50 states and efforts to address it have been essentially a failure nationwide. In 1995 and 1996, for instance, approximately $185 million in federal funds was provided to 47 state Medicaid Fraud Control Units (MFCUs) to support their fraud and abuse detection and collection efforts, but only $71 million—or less than 40% of the amount spent on such detection and collection efforts—was recovered. In 1997 total expenditures in the Medicaid program amounted to approximately $200 billion nationwide, yet in that year the major government agencies charged with addressing fraud and abuse in the Medicaid program, the MFCUs and the Surveillance and Utilization Review Subsystems (SURS) units of the various states, recovered a total of only approximately $250 million. The amounts recovered, however, relate to claims paid over a multi-year period which we estimate totaled approximately $700 billion.

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[1] HealthWatch Technologies, LLC and HWT, LLC are affiliated with Sapient Corporation, an e-services consultancy that helped develop the technology used in the identification of overpayments. The contract for the identification and collection of overpayments in the Medicaid program in Kentucky described in this testimony was initially awarded to Sapient. However, since Sapient's core business does not include the identification and collection of overpayments in the healthcare system, that contract was undertaken with the understanding that it would be assigned to an affiliated organization. HealthWatch Technologies, LLC was formed for the sole purpose of providing these services in Kentucky. HWT, LLC was formed to provide program integrity services to public and private healthcare organizations nationally.

[2] Sparrow, Malcolm K., *License to Steal,* 1996, p.212.

THE UNIQUE APPROACH OF HEALTHWATCH TECHNOLOGIES AND HWT IN THE USE OF INFORMATION TECHNOLOGY TO ADDRESS THE PROBLEM

Our team offers state governments a unique program that has proven to be an effective part of the solution to the problem of fraud and abuse in the Medicaid system.

There are a number of companies offering software products and systems which Medicaid departments can obtain that allow them to analyze their data to identify patterns of aberrant activity and behavior among recipients and providers. With further analysis and investigation of the data, the Medicaid department might then make a determination of overpayment amount as a basis for a recoupment action or an initial determination of possible fraudulent behavior that could be referred to prosecutorial authorities.

The approach of our team is significantly different and offers a great deal more to a state's Medicaid department. We offer a full spectrum service including the provision of all information technology services and necessary hardware, analysis of data, the specific identification of fraudulent and abusive claims that have been paid, the presentation of the evidence to prosecutorial authorities *and the recovery of the funds for the state.* We operate on a contingency fee determined on the basis of repayments received by the state. **We receive no compensation whatsoever, unless the state actually recovers overpayments.** We believe that our business model is the first of its kind and that our approach addresses a very important need which to date has gone unfulfilled. Implementation of this innovative process requires substantial resources in information technology expertise, hardware, software, capital and staffing which are simply not available within state government under present circumstances. The contingent payment mechanism makes use of the recovered funds to supply the resources needed.

*Outline of the Process*

Providers who use abusive or fraudulent billing practices know the claims processing systems as well as those who operate them. They also know that the present state of claims processing technology cannot check the thousands of potential variables and still process claims in a timely manner. Most states have some type of data warehouse to help in the identification of improper utilization, but very few have made material progress in solving the problem because, in addition to a shortage of resources, they lack the process experience, specific knowledge base and the information technologies required.

Our companies employs its own SIEQ© methodology to ensure that all available expertise and technologies are brought to bare on the problem. This methodology employs close examination of applicable policies and claims processing systems, exposing weaknesses that jeopardize fiscal integrity. It then develops algorithms tailored specifically to those areas revealed to be most vulnerable to waste, fraud and abuse. Then, processing of the raw data (paid claims, recipient and insurance data, vital statistics, etc.) against the algorithms produces detailed, line-by-line listings of overpayments by specific providers. These listings represent substantial and immediate recovery opportunities. They are actionable.

Detailed listings of overpayments are then presented to the state's Medicaid staff for final verification. Prior to any overpayment collection activity, all detailed listings are presented to a review board consisting of the appropriate investigative and prosecutorial authorities, the state's Attorney General, the United States Attorneys, and the representatives of the federal Office of the Inspector General, to give these agencies the opportunity to make an assessment as to whether criminal investigation is appropriate. Cases which are selected for criminal review are set aside from the collection process to permit development of possible criminal prosecution by the appropriate agency.

Overpayment collection is undertaken by our team as an agent of the state. Following the state's rules and regulations governing the collection of overpayments and due process with regard to providers' rights to appeal and review, we send providers letters, under signature of the appropriate state official and pre-approved by the state, requesting recovery of any overpayments made. Each letter includes detailed, line-by-line listings of each and every overpayment together with a clear explanation of the reason these payments are in violation of Medicaid regulations. Management of the dispute resolution process is supported by our team under the direction of the state's Medicaid department.

*Proof of the Process: The Kentucky Project*

*The Commonwealth of Kentucky is the first state to demonstrate the vision to implement the full-spectrum approach outlined here, and the results have been extraordinary.*

An enormous amount of Medicaid overpayments have been identified in Kentucky. Working closely with the staff of Kentucky's Department of Medicaid Services, our team [3] has identified specific overpayments in excess of $14 million, most of which we believe can be recouped by our team for the Commonwealth over the next several months. The findings consist of over 160 result sets, each of which details specific line items of paid claims which are part of a particular category of overpayment by service and provider type. Altogether over 2 million line items of paid claims are involved. The hard copy print out of the detailed reports amounts to over 200,000 pages.

In addition to the $14 million in Medicaid overpayments which are proceeding to collection referred to above, we have identified overpayments in the range of $15 million and $25 million which are still undergoing analysis and review by the Kentucky Medicaid Department. We expect collection action to be initiated on this group of overpayments within the next several months, and the bulk of recovery of these overpayments to be made in the three months following.

These findings do not target any one provider group but identify overpayments made to physicians, dentists, medical laboratories, hospitals, nursing homes, pharmacists, DME dealers, rural health centers, transportation providers, home health agencies and others. The overpayments identified in the reports cover a broad spectrum of abuse including duplicate services, upcoding, unbundling, impossible services, etc. By way of example, we have found:

- **Excessive Services:** A small percentage of physicians routinely inflate the amount of time that they claim to be spending with Medicaid clients. Approximately 500 physicians routinely claim that they spend over 15 hours a day with Medicaid clients. Our reports include evidence of numerous physicians routinely charging Medicaid for seeing Medicaid patients for more than 24 hours per day.
- **Excessive Quantities:** Providers are routinely reimbursed for providing services and supplies in quantities that are far in excess of what would be reasonably necessary. This is particularly true with regard to Durable Medical Equipment(DME) providers and pharmacists. As an example certain providers routinely claim to supply patients with over 200 inhalers per month for a charge of over $4,000 each time. Maximum usage of this product is 3-4 inhalers per month at a cost of about $150. One provider routinely claims to provide 90 times the normal supply of a particular pharmaceutical solution, resulting in a per claim payment in excess of $1500 more than what would have been paid if an appropriate quantity had been billed. As another example, there are numerous physicians who routinely charge for up to 5 urinalysis tests each time they perform one.
- **Duplicate Billing:** Several categories of providers routinely submit claims for the same service provided to the same patient on the same day. A typical case is one in which two dentists at opposite ends of the state repeatedly submit claims for extracting the same tooth, for the same patient, on the same day.
- **Inappropriate Services:** Certain providers routinely submit claims for services for which there is no apparent medical necessity. Numerous transportation companies have submitted claims for thousands of ambulance and taxi rides, costing over $500,000 in the aggregate, when there is no record that any medical services at all were provided on the day the transportation service was rendered.

*While our results make it clear that fraud and abuse in the system are pervasive in that all provider and service types are involved, our analysis shows that the abuse is concentrated in a very small group of providers. Typically, the abusive behavior is confined to between 2% and 4% of each provider group.* **The vast majority of Kentucky providers are honest, law-abiding citizens, playing by the rules.**

*Work of the Review Board:*

The Review Board in the Kentucky project consists of the Commonwealth's Attorney General, represented by staff of the MFCU, the United States Attorneys for the Eastern and Western Districts of Kentucky, Kentucky's Office of the Inspector General, and representatives of the federal Office of the Inspector General. At the Review Board's meeting on November 2, 1999, representatives of the Federal Bureau of Investigation were present. The Review Board has met six times over the past several months and the United States Attorneys and the Attorney General's Office have identified the cases of approximately 25 particular providers of various types in which they have determined that the apparent abusive practices are so extreme as to warrant close investigation with a view towards possible criminal prosecution.

[3] See footnote 1.

The Medicaid overpayment amount represented by these cases is in excess of $1.5 million.

*The Collection Phase:*

The first step in the collection phase was undertaken just over two months ago, and the results are extremely encouraging. On August 20, an initial and relatively small set of collection letters (275 letters representing approximately $300,000 in recoverable overpayments) was sent to dentists under the Department of Medicaid Services (DMS) Commissioner's signature. DMS regulations stipulate that providers may dispute its findings of overpayment by indicating in writing their intention to do so within a 30-day period. By September 20, the end of the 30 day period, only 55 of the 275 dentists, that is 20%, had indicated that they had any reservations about our findings. Thus, by regulation the balance of 220, representing about 80% of the providers involved, are obligated to repay the overpayments. We expect that this will result in repayment to the Commonwealth of approximately $250,000, most of which will have been received within the next sixty days.

We believe that collection of the balance of the overpayments identified to date, the $14 million slated for immediate collection action and the $15 million to $25 million still undergoing final review, can be as successfully implemented as the first set has been, and that we can return to Kentucky about 80%, or between $20 million and $30 million over the coming months.

We believe the Commonwealth of Kentucky's Cabinet for Health Services deserves enormous credit for having the wisdom and foresight to begin this effort and to support it as recoveries have been made. We think they represent a model for other states to emulate.

*Future Identification and Recovery of Medicaid Overpayments:*

We are convinced that the overpayments we have identified and will be recovering in the coming months represent a small fraction of what can be developed with a continuation of this effort. The aggregate amount of claims in the Medicaid database we have been working with is approximately $8 billion (claims paid over ≥ 3 ° year period ending June 30, 1998). Thus our findings to date amount to less than ′ of 1% of that amount. Based on the numerous studies that have been undertaken to estimate the extent of overpayments in the Medicaid system nationally, it is reasonable to estimate that the overpayments in Kentucky that could be identified range between $600 and $800 million.

*Significant Reduction in the Cost of Kentucky's Medicaid Program Going Forward:*

Recovering overpayments made to providers in the past is only one of the significant financial improvements that can be made in the Medicaid program. Other substantial financial benefits can come about in two other ways, by preventing the abuse before it happens:

- The first way that abusive and fraudulent behaviors will be reduced in the future is by the powerful "chilling" effect of the collection effort itself. The small percentage of providers abusing the system will understand very quickly that the system will not tolerate their behavior and it will stop. The more overpayments recovered, the greater and more effective the "chilling" effect.
- The second way is that the logic behind many of the algorithms which were used to identify overpayments can be converted into prepayment edits in the program's payment system, thus assuring that these particular abuses will be caught before payment is made in the first place.

*Recommendations for the Subcommittee's Consideration*

We believe that the contingency recovery model described herein and proven effective in Kentucky provides a workable solution to the problem of fraud and abuse in the Medicaid system and should be replicated in other states. Presently we are aware of four other states that are following Kentucky's bold lead and are in the process of implementing this approach.

There is no need for new legislation. Rather, the Health Care Financing Administration needs to encourage states to adopt these innovative approaches to curbing healthcare fraud and abuse in the federally funded health care programs and generally. State agencies which are generally understaffed and overworked should be encouraged to use outside consultants whose main focus is the detection and prevention of Medicaid overpayments. These consultants should not be involved with the payment of claims in the first instance and should be evaluated by HCFA and the States. HCFA should publish a list of approved consultants as they have done so with approved Medicare contractors. States should be encouraged by HCFA to pay these consultants on a contingent fee basis as this method provides the resources and incentive necessary to do the job. At the same time, HCFA must reassure State

Medicaid officials that vigorous yet warranted overpayment collection activities will be protected from provider backlash.

In addition, we would respectfully request and recommend that this Subcommittee continue to hold oversight hearings in order to monitor the progress HCFA and the states are making towards detecting and preventing the enormous amount of overpayments that currently characterize the Medicaid program. Without this continuing oversight, little forward progress is likely to be made.

In conclusion, HealthWatch Technologies, LLC and HWT, LLC would like to share responsibility for safeguarding Medicaid from fraud and abuse. Thank you for the privilege of presenting this testimony.

Mr. UPTON. Thank you very much.

Mr. Viola.

## TESTIMONY OF GREG VIOLA

Mr. VIOLA. Mr. Chairman, members of the subcommittee, on behalf of the partners and employees of Deloitte and Touche and Deloitte Consulting, we would like to thank you for allowing us the opportunity to provide you with this testimony today.

We would like to accomplish two goals: first, to summarize our impressions of the attitude problems and successes in the Medicaid community regarding fraud control; and, second, educate you to our approach as to solving the problem.

First our impression. We have visited 17 Medicaid programs in the last 2 years attempting to market our fraud control solution. Some programs wish the problem would go away, some proclaim it's under control, but most are interested in fighting fraud, and they're often stymied by conflicts within and between departments by politics or by ignorance.

Additionally, no Medicaid program has committed sufficient funding to solve the problem.

And, finally, there need to be significant improvements in fraud detection tools, techniques, technologies and their implementation.

The reasons for this somewhat gloomy situation has been recently documented in the report referenced in the first panel by Dr. Sparrow at HCFA, which we would recommend reading for further information.

On our approach. Our approach to fraud control is both organizationally focused and process focused. I would ask that you follow along with the charts that we're going to try to appear on the screen.

Our organizational focus is concerned with orchestrating cooperation between the various departments, the need to work together to fight fraud. We analyze budget staffing, technology, interactions with outside entities and other related areas. We assign staff experienced in health care reimbursement and claims analysis; in health care delivery, including doctors and nurses; in State governmental operations analysis; in systems and technology; and in investigations, including former Attorneys General staff and FBI investigators.

The hopeful outcome of our organizational focus are changes to the departments to position them for success in fraud detection.

The process focus has several goals: to identify claims improperly paid, whether due to waste, fraud and abuse or error; to determine the mechanisms that allow the claims to be placed in the first place; to implement claims payment safeguards so that losses are prospectively avoided; and to provide the State with requested in-

formation to support either retrospective recovery of revenue, recoupment of the claims against future billings or, where possible, to initiate prosecution.

These goals are accomplished by loading Medicaid claims onto our systems and analyzing those claims with both computer technology and experienced staff analysis.

We review results with the State, assist in interpreting the mechanisms that allow the claims to be paid, and design safeguards against future claims of the same nature. These analyses are applied repetitively as new claims are introduced, both to measure the progress and to identify new emerging scams as they develop.

We would like to conclude our presentation with some graphical examples of the types of analyses we perform using automated tools and to show you what some of the results look like.

This first graphic is the result of an analysis that we ran on a Medicaid program's claims to identify a pharmacy scam where prescriptions are shopped from pharmacy to pharmacy resulting in the prescription being billed and paid for multiple times. In the first panel, you heard about lock-in programs. Application of a good lock-in program will help to deter this kind of fraud from occurring.

First, we processed several hundred millions of claims using technology from HOPS International to identify those claims using that scam. Those results themselves would be sufficient to identify problem transactions for action, and certainly one could pursue those providers solely on that basis. However, we went looking for other relationships between entities on those claims.

This first graphic, using a link analysis tool from I-2, shows that each doctor-patient relationship—and in this chart the doctors fan out from each patient—notice that each patient has many prescribing physicians and, in fact, many more that would be necessary for any one patient.

This second graphic zooms in to illustrate what may be a ring of collusive activities between prescribing physicians and patients. The numbers on each line, if you can see them, indicate how much prescriptions were billed for that patient-doctor relationship. This ring prompted us to look for collusion using cluster analysis.

This next graphic shows cluster analysis performed on the same data using a tool from SAS called Enterprise Miner. The two axis on this chart represent four pharmacies labelled A, B, C, D, and the circles at the intersections of the pharmacies show the probable strength of any interrelationship.

The redder the circle, the more probable that there is a relationship between those pharmacies; the larger the circles, the more transactions would probably occur. If one examines the left-most column of red circles above pharmacy A from the bottom up for a moment, it shows that a patient shopping for prescriptions using pharmacy A has a very high probability of also shopping those prescriptions at pharmacies B, C and D. The volume of transactions, the size of the circle, would be largest with B and successfully smaller with C and D.

A subsequent analysis using decision trees correlating this analysis with prescribing physicians showed that there was also a 99

percent chance that certain specific physicians would be involved in these transactions as well.

While one might be inclined to label this a conspiracy, it could also be stolen IDs being used by a fourth party. What you can infer from this analysis is that the claims tractions shows these physicians, pharmacies and patients—or at least their respective Medicaid numbers—have an usually tight relationship. Only an investigation will tell the true story, however. This analysis allows the scope of an investigation to be narrowed to a few entities rather quickly and a decision made as to next steps.

We thank you for the opportunity to testify.

[The prepared statement of Greg Viola follows:]

PREPARED STATEMENT OF GREG VIOLA, SENIOR MANAGER, DELOITTE CONSULTING LLC

SUMMARY

We have been asked to testify before this Subcommittee to discuss our approaches to the detection and elimination of fraud in the Medicaid program.

We have been supplying services and supporting products to identify Medicaid fraud since October, 1997. Since that time, we have been able to demonstrate the value, from a financial basis, of implementing a fraud control solution. In the pilots we have done, we have been able to quickly reveal (in a few weeks) tens of millions of dollars of opportunity in this area from analyses of Medicaid paid claims. However, the market has been slow to adapt these techniques, for reasons made clear by Dr. Malcolm Sparrow in his recent report to HCFA *"Controlling Fraud and Abuse in Medicaid: Innovations and Obstacles"*, dated September 24th, 1999 (copies available on request). We are hoping this situation changes in the near future.

Our approach, called DETECTTM, is broader in scope than most other approaches. DETECTTM encompasses both an *organizational focus* (to enable the payer—Medicaid programs—to implement and support fraud control), and a *process focus* (to make available systems and methods to implement and institutionalize detection processes in payer organizations.

Since we are a systems integrator and consulting firm, we can select or build software, and adapt our consulting approach, as the needs of the market change. Currently, in addition to our 17+ years of Medicaid consulting expertise and the use of Dr. Sparrow as an advisor, we use database and processing technology from HOPS International, data mining software from SAS Institute, and data visualization software from I2

TESTIMONY

On behalf of the Partners and Employees of Deloitte & Touche and Deloitte Consulting, my colleagues and I would like to thank the subcommittee for allowing us the opportunity to be here with you today. We believe that more interaction like this will enable us all to play more effective roles in the fight against health care fraud.

First of all, some background. Many of you know that we are one of the largest professional services firms in the world, serving the public sector, and most industries in the private sector, all over the globe. Those of us here with you today are concerned specifically with the healthcare payer industry and the impact that fraud has had on both the financial and medical health of the country.

Our specific focus is positioning our clients to be effective in the fraud detection process, and enabling them to subsequently detect and eliminate fraudulent health care claims. We have spent the last two years in the marketplace, working with private and public payers, developing, refining, and delivering what we believe is now the most effective and comprehensive approach to fraud detection.

We would like to accomplish two goals today. First, to summarize our impression of the attitude, problems, and successes in the payer community regarding fraud control. Second, we would like to educate you as to our approach to solving this problem. Let's begin.

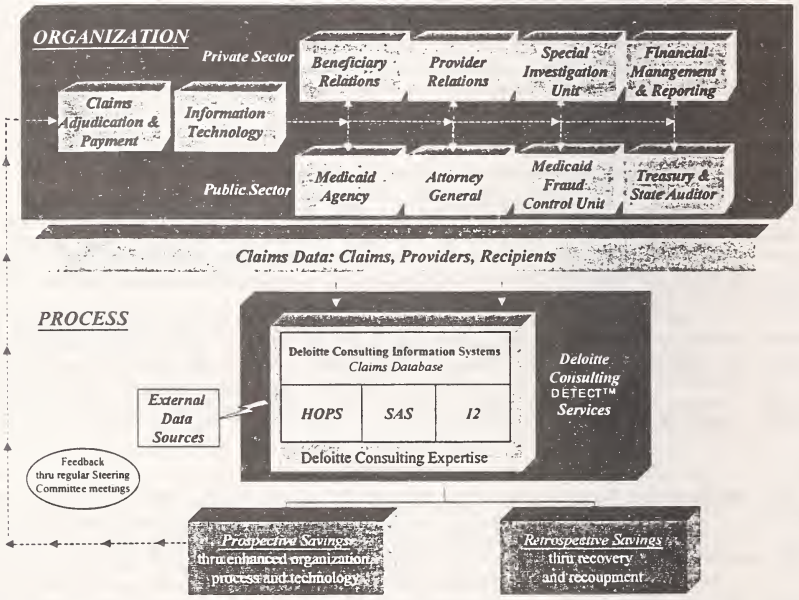
**Our impressions:** We have found that a wide variety of models exist in private and public payer organizations regarding the pursuit of health care fraud. Some simply wish the problem would go away. Some merely cite current efforts, and then proclaim that they have the problem under control. Some program approaches are mired in politics, or in ignorance, or both.

Some programs are truly interested in eliminating the problem, and strive to rise above these issues to address fraud effectively. However, they are often stymied by problems within their own departments, and with other departments in the State. Aside from attitudes, though, not enough payers, public or private, are devoted to solving this problem effectively, and no Medicaid program appears willing to commit sufficient funding, time, and effort to solve the problem.

There are many reasons for this current situation. We would suggest a review of Dr. Malcolm Sparrow's report to HFCA, dated September 24th, 1999, for a detailed discussion of those reasons. This report documents the results of four regional seminars, sponsored by HFCA and conducted between December of 1998 and May of 1999, on the subject of Medicaid fraud and abuse control. These seminars were attended by representatives from 49 states. We include two quotes below from the report, both from page 12, to illustrate the problem:

> "legislatures and senior management... appeared either not to recognize the problem of Medicaid Fraud and Abuse; or if they did, they did not seem to treat it as a serious or central issue in program administration"
>
> "the culture of social service agencies and claims processing operations appears to be adverse, and in some cases openly hostile, to the purposes and methods of effective fraud control"

**Our approach:** Our approach is both organizationally-focused and process-focused. The following chart summarizes our approach:




The *organizational focus* is concerned with making sure the multiple departments in the State that need to cooperate to identify and pursue fraud are poised to work together effectively. This involves an analysis of their budgets, staffing & skill levels, degree of technology sophistication, available technology support, interactions with each other and outside entities, etc. To perform this analysis, we assign staff experienced in health care reimbursement and claims analysis, in health care delivery (including doctors and nurses), in state governmental operations analysis, in systems and technology, in data mining, in fraud detection, and in investigations (including former Attorneys General staff and FBI investigators). The outcome of the organizational focus are recommendations regarding changes to the departments within the organization to position it for success in the fraud detection environment.

The ultimate goals of the *process focus* are:

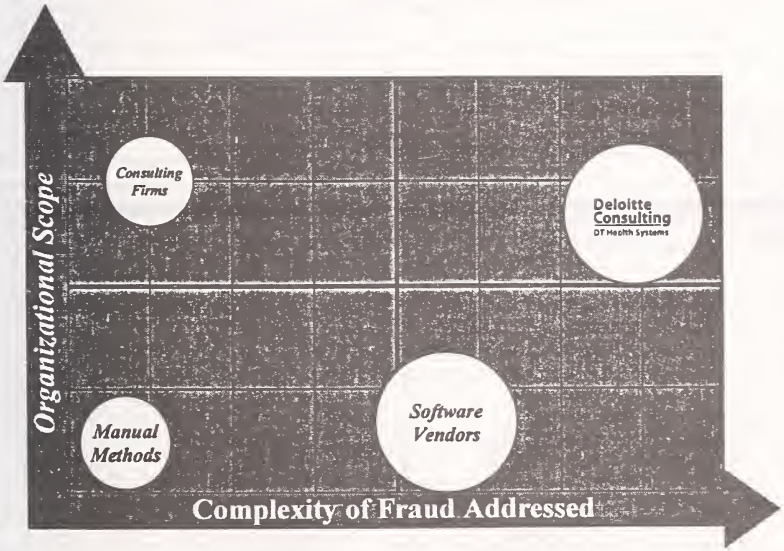
- To identify claims improperly paid, whether due to fraud, waste, abuse, or error;
- To determine the mechanisms that allowed the claims to be paid in the first place;
- To implement claims payment safeguards so that losses are prospectively avoided; and

- To provide the payer with requested information to support either retrospective recovery of the revenue or recoupment of the claim against future billings, where possible; and/or to initiate prosecution.

These goals are accomplished by acquiring the claims from the payer, loading them onto our systems, and analyzing those claims with both computer technology and experienced analysis staff. We spend a great deal of time reviewing results with the State staff, assisting in interpreting the mechanisms that allowed the claim to be paid, and designing the safeguards against future claims of the same nature. These analyses need to be applied repetitively as new claims are introduced, both to measure progress, and to identify new emerging scams as they develop.

Our greatest asset in this endeavor is our extensive knowledge of fraud scams. We have built this knowledge from our relationship with Dr. Sparrow, from our own experience, from our clients, and from available published reports. Since we are not a technology vendor, but a consulting firm and technology integrator, we can utilize whatever technology works the best to implement that knowledge. We have currently integrated software from HOPS International, SAS Institute, and I2. This supplies us with database management and claims processing, data mining (such as neural networks and decision trees), and data visualization, respectively.

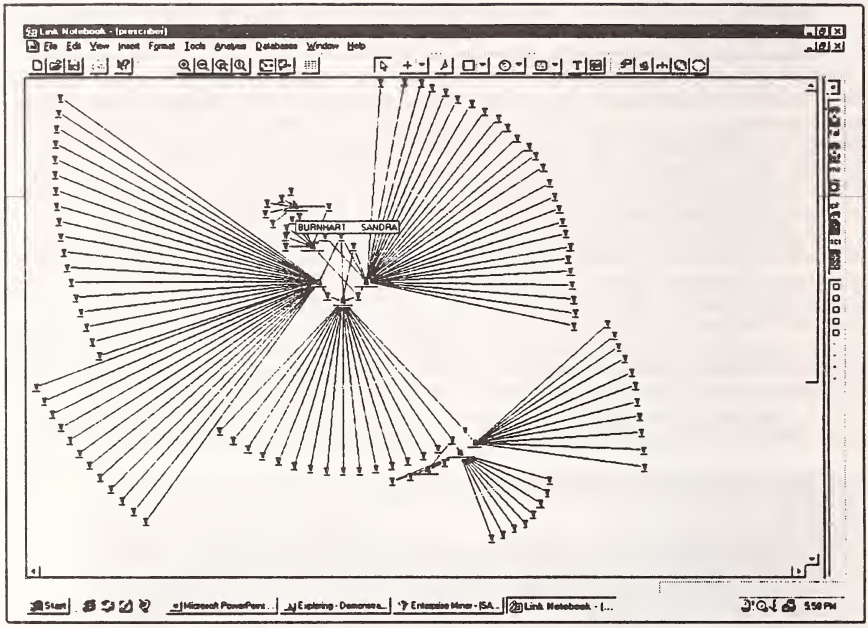
This combined focus allows to address most of the significant issues regarding implementation of a fraud control solution, as illustrated in the following chart.

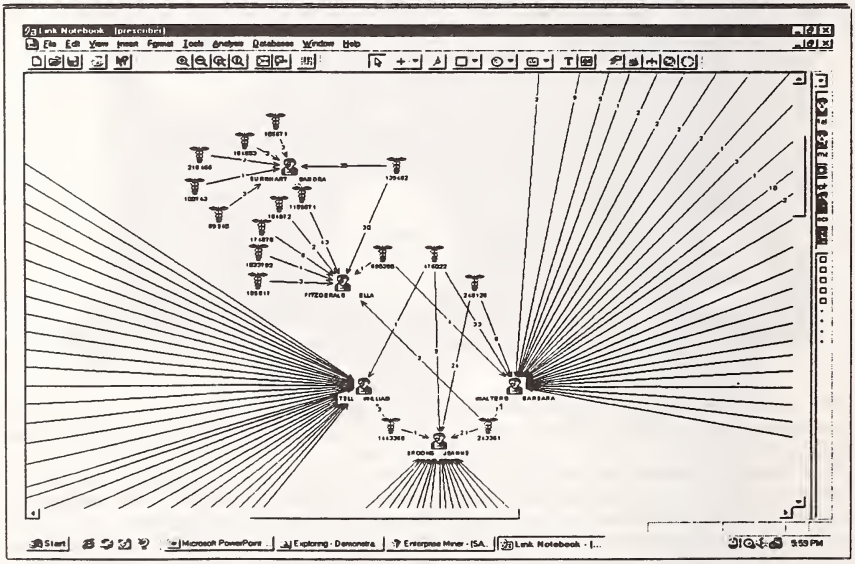



We would like to conclude our statement with some graphic examples of the types of analyses that we can perform using these techniques, and what the results look like.

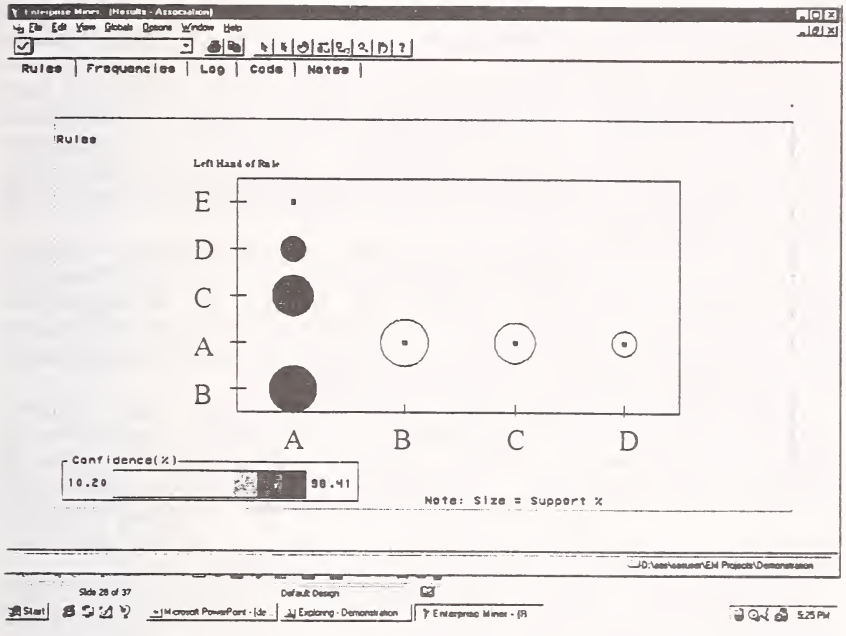
The first graphic is the result of an analysis we ran on a Medicaid program's claims to identify a pharmacy scam where prescriptions are shopped from pharmacy to pharmacy, resulting in the prescription being billed for multiple times.

After processing several hundred million claims using the HOPS technology to identify those claims meeting that scam, we fed the suspect claims into the I2 link analysis tool. This first graphic shows the all each doctor that prescribed for each patient, connected by a line (the doctors "fan out" from each patient). Note that each patient has many prescribers, many more than would normally be necessary for any one patient. The second graphic zooms in to illustrate what *may* be a ring of collusive activities between prescribers and patients.



The next graphic shows additional analysis performed by feeding this same data through the SAS Enterprise Miner tool. We ran a cluster analysis, which shows the probability that clusters of certain pharmacies will be shopped by any individual patient.




If one examines the red (dark) circles, a patient shopping prescriptions using pharmacy A has a very high probability (98%) of also filling prescriptions at pharmacies B, C, and D. The volume of the occurrence is predicted by the size of the circle. A subsequent analysis shows that there is also a 99% chance that certain physicians will be involved in the transactions as well. While one might be inclined to label this a conspiracy, it could also be stolen IDs being used by a fourth party. What you *can* infer from the analysis is that these physicians, pharmacies, and patients have an unusually tight relationship. Only an investigation will tell the true story, however, the scope of the investigation can be narrowed to a few entities rather quickly, and a decision made as to next steps.

The payback from such an analysis can be immediate. In another instance, we identified a large number of discrepancies in a Medicaid program's billings after approximately one week of analysis. Selecting one provider, the State decided to go on site and ask a few questions (not conducting an actual investigation). The provider was a pediatrician who was continually billing the highest level of service available, which would only be reasonable if his patients were all severely ill all the time. Upon the arrival of the State's team at the doctor's office (in a storefront in a housing project), the provider immediately confessed. The value of his billings were over $1.0M/year, of which 25% conservatively was overstated, resulting in a minimum $250,000 per year of immediate savings from this one case

We would be pleased to discuss these and other related topics at length, and you may arrange such a meeting by contacting Ed Ruzinsky at (732) 296-6280.

Mr. UPTON. Thank you.

Mr. Glynn.

## TESTIMONY OF MICHAEL J. GLYNN

Mr. GLYNN. Chairman Upton, distinguished subcommittee members, thank you very much for the opportunity to testify here this morning. Accompanying me is, on my left hand, is Dr. Philip Caper, who is the founder and chairman of the board of the Codman Group. I am pleased to have this opportunity to present the Codman Group's experience of working with State and Federal program managers in the assessment of provider integrity.

Additionally, I wanted to discuss with you our understanding of the challenges and opportunities in fraud detection using today's most advanced technology.

Fraudulent claim volume is a very small subset of a large universe of transactions and the corresponding number of fraudulent providers is relatively small. Therein lies the one major challenge, how to effectively identify the fraudulent transactions without imposing processes and barriers that interfere with the underlying mission of Medicaid.

Adding to the challenge, the individuals and institutions committing the fraud are continually creating new schemes and seeking to camouflage themselves against the background of legitimate transactions. As a consequence, the detection of fraud is a dynamic and complex process. No single methodology and no static approach can adequately protect our public programs.

Furthermore, fraud detection may interfere with the requirements to assure adequate access to care. Medicaid programs work diligently to create broad-based provider networks for eligibles in areas that are historically underserved. Chief are the inner city and rural areas. Program managers should not be forced to alienate scarce but honest providers as a by-product of the hype and surveillance needed to identify the fraudulent ones.

Fraud detection systems which analyze claims data without considering the patient's age, gender and level of illness will erroneously target legitimate transactions, yet may ignore others that represent unnecessary expenditure. To avoid unfairly accusing honest providers and wasting investigative resources, an anti-fraud system must consider and adjust for patient level of illness.

Adjusting for the complexity of a provider's patient population will dispel the concerns about higher than average yet legitimate bills charges. Advanced detection systems that comprehensively review claims and present well-documented, highly targeted lists of suspects can greatly aid investigators and limit intrusions on providers.

Let's look at the nature of the environment facing these new systems.

Medicaid claims data are messy. Data originates from multiple systems, making it difficult to weave together the claim history of providers and eligibles. Additionally, many investigators lack the training required to effectively analyze the data. To address this issue, new detection systems support the investigator's judgment without requiring the investigator to develop technical expertise.

A single claim record may not by itself look unusual. Many forms of fraud can only be effectively identified when multiple related claims are linked together. Linking claims illuminates relationships amongst collusive providers.

I would now like to present some examples of the findings that represent our experience using a combination of fraud detection tools.

If you can draw your attention to the first slide that's on the screen, this is a project with Texas Medicaid that commenced in 1998, is ongoing. Up to this point, over $70 million of potential overpayments have been identified, approximately 5,000 potential suspects have been identified as a result of the case investigations

that are ongoing. To this point, a total of $5.5 million have been deemed collectible, and so far a total of $3 million has been recovered as a direct result of the project, meaning that the project has more than paid for itself already with lots of opportunity left to go forward.

The second example is a Medicare Part B fraud project in California. I know it's Medicare and this is Medicaid, but the application of the technology is the same. What happened was that providers in an eight county region of California were profiled, claims from approximately half a million beneficiaries were processed.

The system, our project, identified over $10 million in potential overpayments. It strengthened the case against 28 providers who were already on alert as a result of the existing systems that Medicare had in use, which put another $5.5 million in question, and it identified a potential $2.4 million in questionable service that had not been picked up by the existing systems, and through the adjusting for the illness part of the patient population eliminated $2 million in false positive activity that had been picked up by the system. All of this was achieved for a direct cost of less than half a million dollars.

Let's look at an example of one provider from this most recent project, the California project that was identified as having suspect billing activity. As you see in the slide, of the providers total billing, 60 percent of the charges were driven by three questionable—to put it mildly—procedures. A total of over half a million dollars is billed—and going through the first four bullet points, comparing them with the peers, obviously far in excess of what his peer groups were performing.

In addition, it's interesting to note that almost 100 percent of the services were performed on dual eligibles, both Medicare and Medicaid eligibles.

Looking further into the provider profile, there's a preponderance of referrals coming from a single referring physician, $237,000 of the $584,000 billed came from a single physician. And looking at this physician, the referring provider has an unexplained concentration of referrals in two areas, neurology and podiatry. This is a clear example of collusive patterns that are too prevalent in the health care system and can be detected using modern detection fraud and detection tools.

In conclusion, I want to stress that technology exists today to better identify fraudulent activity, abusive practices and wasteful spending in health care and to do so in a clinically sensitive matter. We must invest in the newer technology that implies multiple fraud detection methods simultaneously and does so in a clinically responsible manner that supports the goals of the legitimate provider community. Achieving this is critical if we're to protect and preserve the care and quality of care in Medicaid.

Thank you very much for the opportunity.

[The prepared statement of Michael J. Glynn follows:]

PREPARED STATEMENT OF MICHAEL J. GLYNN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, CODMAN GROUP

Chairman Upton and distinguished Subcommittee members, I am pleased to have this opportunity to present the Codman Group's experience of working with state and federal program managers in the assessment of provider integrity. Additionally,

I want to discuss with you our understanding of the challenges and opportunities in fraud detection using today's most advanced technology.

One needs to look no further than the most recent headlines to confirm the magnitude and complexity of fraud in Medicaid. The most recent estimates suggest that 10 to 20 percent of our national health care spending is fraudulent with the dollar value loss estimated to be $20 Billion annually. However, the fraudulent claim volume is a very small subset of a large universe of transactions and the corresponding number of fraudulent providers is relatively small. Therein lies the one major challenge... How to effectively identify the fraudulent transactions without imposing processes and barriers that interfere with the underlying mission of Medicaid, providing needed care to the legitimate beneficiary.

Adding to the challenge, the individuals and institutions committing the fraud are continually creating new schemes and seeking to camouflage themselves against the background of legitimate transactions. As a consequence, the detection of fraud is a dynamic and complex process. No single methodology and no static approach can adequately protect our public programs. Clearly the current Medicaid Surveillance Utilization Review or SURS subsystem is not adequate. Emerging effective fraud detection systems are characterized by the integration of multiple and diverse analytical approaches ranging from statistical methods to data mining and data modeling.

Furthermore, fraud detection may interfere with the requirement to assure adequate access to care. Medicaid programs work diligently to create broad based provider networks for eligibles. In areas that are historically under-served, chiefly the inner city and rural areas, program managers should not be forced to alienate scarce, but honest providers as a by-product of the heightened surveillance needed to identify the fraudulent entities. The American Medical Association newsletter, AMA News, recently headlined the outcry of providers in Utah who were incensed by unjustified surveillance and intrusive activity of fraud investigators.

The fraud detection process is further complicated by the diversity of the patient population that presents itself to the medical community. Medicaid eligibles include the young and the old, the mostly healthy and the seriously ill. The proper and needed degree of medical intervention, with its associated cost, hinges greatly upon the patient's multiple conditions. Therefore, fraud detection systems which analyze claims data without considering the patient's age, gender, and level of illness, will erroneously target legitimate transactions, yet may ignore others that represent unnecessary expenditure. To avoid unfairly accusing honest providers and wasting investigative resources, an anti-fraud system must consider and adjust for patient level of illness. Adjusting for the complexity of a provider's patient population will dispel concerns about higher than average, yet legitimate, billed charges. Clinical sensitivity is paramount.

The standard approaches used to detect potential fraud and abuse can exacerbate the frustration felt by legitimate providers. For example, providers whose practices are reviewed as a result of random sample audits may feel singled out. Instead, advanced detection systems that comprehensively review claims and present well documented, highly targeted lists of suspects can greatly aid investigators and limit intrusions on providers.

Fraud detection results must be substantiated through sound statistical methods. Often, these methods will sufficiently strengthen the case for fraud and incent the provider to return funds. Failing that, a strong statistical foundation will support successful prosecution.

There are other reasons why Medicaid programs are slow to respond to the expanding fraud. First, there are significant disincentives to increase suspect identification rates because the increased prevalence may call into question the competence of program management. Second, money recovered by program or related agency investigators is not likely to accrue to the Medicaid program. In fact, money identified as overpayment may serve to justify program budget reductions.

But even if we overcome these hurdles by properly incenting the program to increase surveillance and recovery, the task is large. Let's look at the nature of the environment facing these new systems.

Medicaid claim data is messy. Data originates from multiple systems, making it difficult to weave together the claim history of providers and eligibles. Fraud investigations involve diverse organizations which may lack shared access to the report systems needed to identify and build the case against a provider. Additionally, many investigators lack the training required to effectively analyze the data. To address this issue, new detection systems must support the investigator's judgement without requiring the investigator to develop technical expertise.

A single claim record may not, by itself, look unusual. Many forms of fraud can only be effectively identified when multiple related claims are linked together. Linking claims illuminates relationships among collusive providers. It highlights improb-

able rates of service intensity and points out practice patterns that deviate from peer group norms. Effective detection systems must take into account the linkages and interrelationships among claims, eligibles and providers.

Another pivotal change in our approach to improved fraud detection will be the ability to examine claims and data across borders. One example is HCFA's current initiative to apply advanced detection tools to national-scale Medicare data. Why is this important? Consider the following quote from an article in the November 4, 1999 issue of the *New York Times:*

> The (General) Accounting Office said these "organized criminal groups tend to be quite transient," and should not be confused with traditional organized crime groups like the Mafia... In one case, it said, suspects fled from New Jersey to California and started new operations on the West Coast before they could be arrested for violations that had occurred in New Jersey. In other cases, it said, New Jersey shut down several clinics but later found that "the New York Medicaid fraud control unit was investigating the same individuals for different schemes."

By examining claims on a national basis, these transient scammers can be better identified and intercepted.

Fraud that spans multiple states presents a particular problem for Medicaid programs, where program integrity efforts end at the state's borders. In these cases, a focused national effort to create cross border analytic programs could identify problems that only become evident when their multi-state scope is exposed. Even more powerful would be an effort to coordinate Medicaid and Medicare analysis, since undoubtedly many of the same illegitimate actors are submitting claims to both. Fraudulent providers prey on our most vulnerable populations, specifically the poor, frail and elderly. New approaches must be put in place to improve the coordination of care to the Medicaid-Medicare eligible population.

I would like to present a sample of the findings that represent our experience using a combination of fraud detection tools.

*Medicare Fraud, Waste and Abuse Pilot Project Supported by HCFA through the Program Integrity Contractor National Heritage Insurance Company (NHIC)*

- Profiled providers in an eight county region in California
- Reviewed claims of nearly 500,000 Medicare beneficiaries
- Identified $10 Million in potential inappropriate payments to providers
- Strengthened the case against 28 providers who were already on alert—$5.5 Million in question
- Identified $2.4 Million in questionable service by providers not previously under surveillance
- Eliminated $2 Million in false positive activity

*Texas Medicaid Fraud Detection Project 1998-99*

- More than $70 Million has been identified as potential overpayment
- Produced 4,953 new suspects
- Total of $5.4 Million deemed collectible as a result of case investigations
- Total of $3 Million recovered to date as a direct result of the project

In conclusion, I want to stress that technology exists today to better identify fraudulent activity, abusive practices, and wasteful spending in health care, and to do so with clinical sensitivity. The fraud problem is too big to ignore. Current system design for fraud detection in the Medicaid Management Information System or MMIS is only marginally useful. We must invest in newer technology that employs multiple fraud detection methods simultaneously and does so in a clinically-responsible manner that supports the goals of the legitimate provider community. Achieving this is critical if we are to protect and preserve the quality of care in Medicaid.

Mr. UPTON. Thank you.

Ms. MacQuarrie. Am I saying that right?

Ms. MACQUARRIE. It's MacQuarrie, it's Scottish.

Mr. UPTON. I'm sorry.

## TESTIMONY OF JEAN MACQUARRIE

Ms. MACQUARRIE. Mr. Chairman, members of the subcommittee, my name is Jean MacQuarrie. I'm a vice president and the fraud and abuse practice leader for the Medstat Group, which is based in Ann Arbor, Michigan.

For the past 18 years, the Medstat Group has specialized in providing health care decision support systems. These systems consist of customized data bases and analytic software that is specifically designed to help health care programs manage the costs and quality of health care services.

In addition, we provide analytic consulting services that help our customers use these applications effectively. Today we are working with over 1,000 health care purchasers, payers, providers and researchers. Our clients include companies like General Electric, the Ford Motor Company, Federal Express, managed care organizations like Humana, Prudential and Cigna and the Mayo Clinic, and we work today with over 17 State Medicaid programs.

We get input for the design and development of our applications from those customers that we work with. Fraud detection and investigation is a major way in which many of our Medicaid clients use our systems.

I have worked in the field of health care fraud investigation for 8 years, and I agree with the testimony that has been presented today, both in Panel I and from my cotestifiers here today.

The sheer volume of Medicaid claims data makes searching for fraud like looking for needles in a haystack. It really requires the implementation of advanced computer technology that is designed specifically to ferret out the kinds of problems that were perpetrated by organized crimes and others that would defraud the Medicaid program.

We discussed earlier that most States today use fairly outdated application software in their fight against fraud and abuse, and we would encourage this committee to encourage their State counterparts to acquire this advanced technology to help in the fight against fraud and abuse. To address fraud more effectively, these computer systems can be used both prospectively and retrospectively. By prospectively, I mean that some claims as submitted can be detected as being fraudulent and should be stopped before they were paid, and that is where the major focus of health care fraud and abuse detection should be.

However, there are certain types of claims that were submitted that will never be detected prospectively and can't be stopped. So retrospective data analysis is critical to identify the kinds of problems that are being perpetrated within these State organizations and then to document the algorithms used to find those kinds of fraud and to put them into the payment systems to stop the outlay.

An example, an ambulance provider submits a claim for transporting a patient, administering advanced life support from location 1 to location 2. That claim will edit appropriately and be paid by most claim payment systems that were used in the Medicaid program today.

However, when you combine all of the experience, not only of the ambulance company in terms of the patients who were being transported but also the providers in that same community who provide emergency room services, who provide dialysis services to those recipients, it can easily be determined when an ambulance company is defrauding the State organization, perhaps by billing for advanced life support for virtually 100 percent of the patients that they transport. And we know that that is not a likely scenario.

These data mining tools can be deployed in many different fashions, neural-based tools, rules-based algorithms. One of the major benefits or one of the significant attributes of a rules-based system is that it takes health care experts in the field who have been dealing with health care transactional data for many, many years and imbeds that logic into these sophisticated computer applications so that they can look for differences from the norm.

I would like to review for you a few examples about how some of our customers are using this advanced technology in the fight against fraud and abuse. The first example is an actual case for one of our Medicaid customers that serves over 600,000 recipients at a cost of approximately $2.3 billion per year. Using the Medstat system, this State identified many pharmacists who are billing for a higher pill count per prescription than was ordered by the provider.

This problem was detected using normative algorithms and looking at frequency of distribution and comparing providers against peer groups based on diagnosis and other kinds of health care information. The Medstat system helped the State Attorney General's office develop their case and this State is hopeful that it will recoup millions of dollars in this single case alone.

This same State used the Medstat system to identify abuse of home health care billing services. The State found that there are some home health agencies who are providing services to patients who had been designated to be in a nursing home. The State estimates that it will recover $25 to $50 million from this single case of health care fraud as detected with these computer systems that we're up here talking about today.

For another system, for another customer, our State identified a chiropractor who was enticing patients into the practice, offering free initial consultations and then in fact billing for the maximum limit of chiropractic benefit as offered by the program in that State. At the time that each of these patients reached their maximum allowed benefit, the chiropractor moved the patient into physical therapy and continued to bill for that patient. This chiropractor was successfully prosecuted, was sentenced to 8 months in jail and was ordered to pay restitution.

I have actually brought a demo of how this system works with me today. But I also am out of time. I would invite any of the committee members at the break of the question and answer session to perhaps step forward and I can show you how these technological tools are working.

I would like to thank you very much for inviting me and the Medstat Group to present to you today. Thank you.

[The prepared statement of Jean MacQuarrie follows:]

PREPARED STATEMENT OF JEAN MACQUARRIE, VICE PRESIDENT FOR BUSINESS DEVELOPMENT AND FRAUD AND ABUSE PRACTICE LEADER, THE MEDSTAT GROUP

My name is Jean MacQuarrie, Vice President at The MEDSTAT Group, headquartered in Ann Arbor, Michigan. For the past 18 years MEDSTAT has provided information systems to the health care industry. Our software applications analyze health care utilization, cost, access, quality, eligibility and clinical outcomes. Fraud and abuse detection and investigation is a core component of our product line. I am the Fraud and Abuse Practice Leader at MEDSTAT. For the past eight (8) years I have worked in the development and utilization of information technology to help mitigate the impacts of health care fraud.

Much like Medicare, because of the sheer size of the Medicaid Program, health care fraud is very difficult to detect and to prove. The majority of all Medicaid physicians and other health care providers are legitimate. These tens of thousands of honest providers submit hundreds of millions of claims each year for services provided to the Medicaid population. Hidden among these legitimate claims are millions of fraudulent claims. One of the great difficulties in identifying false claims is that the volume of legitimate claims camouflages them. It is literally like looking for needles in a haystack. However, as experts who will testify here today will state, these needles amount to billions of dollars of inappropriate payments made each year in the Medicaid program.

I am going to discuss how new and advanced health care analytic information systems can be deployed to significantly improve fraud and abuse detection and investigation results over the methods that are used by most state agencies today. There are a few State Medicaid programs that have recognized that these advanced technologies can improve their fraud mitigation programs and they have implemented new solutions or are in the process of procuring new systems.

The vast majority of states, however, continue to review provider billing using an information technology infrastructure that was developed in the 60's and 70's. The Medicaid Management Information Systems (MMIS) provide the software and data files that enroll providers, enroll beneficiaries, pay claims, provide management reporting and audit processed claims using an application called the Surveillance and Utilization Review System (SURS). The SURS systems are used by many states as their entire fraud detection solution. These systems produce large stacks of quarterly reports that rank providers and suppliers on various dimensions of utilization of health care procedures. These systems were designed to look for billing irregularities, not fraud, and the reports they generate are labor intensive to review. It is not cost effective or timely to use state personnel to try and detect fraud by reviewing claims reports from conventional SURS technology. Our recommendation is that state Medicaid programs move swiftly to replace or augment their SURS applications with advanced health care analytic systems that provide comprehensive methods for detecting and investigating fraud, waste and abuse.

In the last ten years, hardware and software technologies have both improved dramatically. Advanced and intelligent health care analytic methods have also been developed. These methods are being used today to measure the effectiveness of the health care delivery system. With these methods and technologies companies are performing tele-medicine, measuring the effectiveness of drugs on specific illnesses, evaluating the outcomes of different treatment protocols and making a real improvement in the way health care services are provided. We can use these same information technologies and health care analytic methods to help in the fight against health care fraud and abuse. The MEDSTAT Group, the company that I represent, provides this type of technology to state Medicaid programs as well as large employers, insurers and managed care plans across the country.

There is no "one silver bullet" technology that will eliminate all fraud, so it is important to apply these technologies and methods both prospectively and retrospectively. Some submitted claims can be identified as being fraudulent at the time the claim is submitted, before it is paid. For instance, if a provider submits a claim for a wheel chair for a deceased person, or for speech therapy for a nursing home comatose patient, the claim should be rejected, and not be paid. These types of claims, however, get paid every day. The reason is that many claims payment systems do not have access to death records and many claims payment systems do not store the cognitive status of patients in nursing homes.

In addition to "pre-payment fraud edits", it is also critically important to analyze data "retrospectively". It is generally understood that most health care billing fraud is not conducted by physicians, but is perpetrated by suppliers and ancillary individuals who set out to make money from the vulnerabilities in the health care delivery system. Truly fraudulent providers and suppliers are very creative in the way that they steal money from the Medicaid program. They study the payment manuals; they submit bills for seemingly legitimate services that will pass pre-payment edits. It is only by looking at all services collectively that the fraudulent pattern emerges. For instance, if an ambulance transport provider submits a bill for a transport to the emergency room, along with the administration of advanced life support, the submitted claim will pass all edits and the transport company will be paid. However, by looking at all bills submitted by that same transport provider, over time, it may be detected that 1) 100% of all their transports required advanced life support—and that's not very likely—or 2) an inordinate number of their patients were not from the same geographical location as the transport company, or 3) that many of the patients that they transported didn't receive any other services on the same

day as the transport. These types of frauds can be detected using retrospective data analysis.

Retrospective data analysis, "*data mining*", can be deployed in several ways. Each of the following can and should be applied, as they find different kinds of frauds:

- *Rules-based algorithms*—that are based on having health care experts define legitimate and non-legitimate "rules" of billing and having the application software "mine" the data looking for exceptions to the rules. A rule might identify any provider who bills for more than 20 or 24 hours in a work day, frequently.
- *Anomaly-based detection*—that combines expert-based rules with advanced health care methodologies and/or computer-based statistical methods to "mine" the data looking for anomalies in the data. This method might identify providers who are significantly different in their billing pattern that their peers, resulting in their pattern falling inside or outside of a cluster.
- *Neural-based detection*—that results in the computer application "learning" through advanced technological processes intended to mirror the non-linear thinking of the human brain. Neural-based detection technology learns from its own processing of the data to understand complex patterns within a particular data set. Thus, "normal" and "abnormal" patterns of behavior can be automatically established to aid in the detection of fraudulent activity.

One major advantage of deploying retrospective data analysis is that as fraud scams are identified, they can be documented and the algorithms that were used to detect them can be "programmed" into the payment system, stopping the scam and preventing further payout for the same fraudulent scheme. Another benefit is in identifying the most suspicious of the providers. Most states have a limited budget to ferret out fraud in the Medicaid program. It is important that the state staff focus on the most egregious providers. With advanced analytic software, fraudulent providers can be pinpointed more quickly and with greater likelihood of identifying "real" fraud, thus focusing investigative resources on the tasks that will produce the highest return on the government's investment of time and money.

Let me show you a few examples of how rules-based data mining can bring data to life, identifying patterns in the data that would be very difficult to detect if it weren't for the power of the technology and the imbedded health care knowledge.

*Scenario 1*

One of our customers is a large Medicaid program that oversees the healthcare services for 600,000 recipients at a cost of approximately $2.3 billion per year. Using the MEDSTAT system, state officials were able to identify pharmacy providers who were overbilling Medicaid by dispensing and billing for a higher pill count than were ordered by the providers. The MEDSTAT system was used to investigate these providers and develop evidence for use by the state Attorney General office, which is pursuing a class action suit to recoup these overbillings. If successful, the suit is expected to recoup millions of state dollars paid to these pharmacies.

*Scenario 2*

Additionally, this same State used the MEDSTAT system to identify and investigate abuse and waste in home health services. The State found that some home health agencies were continuing to provide services to patients that should have been in a nursing home. The State is seeking to move these patients into nursing homes, where appropriate, and will prosecute those cases that involve abusive billing practices. Based on initial assessment, the State expects to recoup $25 to $50 million in savings from this one case alone.

*Scenario 3*

For another customer, our system identified a chiropractor that was offering a "free" initial consultation and then charging for the second visit as if it was the first. In addition, this chiropractor was charging the maximum allowed ($1000 annually) for chiropractic service and then was switching the patient to "physical therapy" so that additional treatment would be covered by insurance. The MEDSTAT system was also used to identify all patients of this chiropractor, who was billing under multiple provider names and identification numbers. This chiropractor was successfully prosecuted and was sentenced to 8 months in jail plus restitution.

*Demo Scenario 4*

A fourth situation is exemplified in the system demonstration I am about to show you. [System is demonstrated, time permitting]. In this instance, the system is highlighting a potential abuse for further investigation. The system in this case is helping us discern the providers who are ordering an inordinate number of prescriptions for their patients.

*Demo Scenario 5*

Another situation also is exemplified in the system. [System is demonstrated, time permitting]. In this case, a podiatrist is identified who should be investigated based on his/her billing patterns in terms of 1) the number of services billed per patient, 2) the utilization of procedures that no other podiatrist uses, and 3) using the same unusual services on each patient, at the same frequency.

In addition to the application of health care analytic systems and technologies to improve State Medicaid program results in fraud and abuse detection, there is an administrative approach used by many states that could be improved upon. In many states, the same fiscal agent and/or computer application (MMIS) that edits claims for legitimacy and payment is also used to audit those same claims for legitimacy (SURS). This is somewhat like the fox watching the hen house. HCFA has recognized a similar problem in the Medicare program and has moved to address it. Through the Medicare Integrity Program (MIP) Program Safeguard Contractor (PSC) program, Medicare has stepped out to aggressively contract with different vendors to provide fraud and abuse detection services from those that provide the claims payment function. The MEDSTAT Group is part of a HCFA-qualified MIP/PSC team.

HCFA has recently stated its interest in allowing state Medicaid programs to also separate the MMIS payment function and the SURS audit function. Some states, like New Hampshire, are implementing this separation of functions now. Other states find it difficult to separate these functions and are contracting with the same vendor to provide the payment and the audit software. We encourage Congress to support the position that each state should contract separately for these important applications.

In summary, we believe that Congress can help states in this most important battle against fraud and abuse. Congress can encourage state Medicaid programs to incorporate advanced information technology solutions to help them in their fraud and abuse mitigation efforts. As is clearly shown with the few examples that I have presented, the investments made by State Medicaid programs for these applications will more than pay for themselves while at the same time, identify fraudulent and abusive providers and conserve funds for the true service mission of the Medicaid program.

The MEDSTAT Group appreciated this opportunity to share our suggestions with you today.

Mr. UPTON. Thank you.

I know we're sort of running out of time. I'm going to yield first to Mr. Burr.

Mr. BURR. Mr. Chairman, I thank you for yielding.

I apologize to these witnesses because I'm already 35 minutes late for a lunch that is my lunch, and I need to go to it. But I wanted to hear your testimony.

Let me take this opportunity to ask, is there still anybody in the room from HCFA?

Mr. Chairman, I would make a note there is no one here from HCFA and——

Mr. UPTON. We have one hand in the back, a late entry.

Mr. BURR. I would only make this note.

Mr. UPTON. A graduate of Wake Forest, I'm glad he does his homework.

Mr. BURR. This issue is important enough that we're holding a hearing, this is taxpayer money we're trying to account for, we've got some of the companies here who have developed software and hardware to help us detect what has become a very complicated and sophisticated scam project across the country of Medicaid moneys, both State and Federal taxpayer money.

I think that this committee would be smart to recommend in the future that any time we hold a hearing that the agencies, if they're allowed to testify, are required to stay and listen to what the individuals that we've pulled together who we perceive to have something to pertinent to tell the committee members, that the agencies

would be nice enough to stay and have the information shared with them, so we don't have to rely on them going back and reading it.

And again I thank these witnesses and yield back my time.

Mr. UPTON. Thank you, Mr. Burr; and we appreciate your assistance in this hearing today.

I, too, have an event that started 35 minutes ago, so I will be a little bit short.

I would say that we are going to keep the record open. We have a number of different subcommittees that are meeting today, full committees as well. There may be a number of members that have additional questions, and we will ask—I will can ask unanimous consent that any of us may submit questions to you, and if you can respond in a prompt fashion, that would be good.

We want all of the States to have the tools, and from the first panel, we heard that a number of States are using technology that is 10, even 20 years old. How difficult—how easy has it been for you all who have marketed some of this technology and obviously have a self interest to make sure that it proceeds well, but at the same time you also have an interest for the taxpayer money as well—I would have to think that in virtually every case you're going to save the taxpayers' money, you know, by the sale of your technology. How easy has it been to open up some of the doors and actually get your technology accepted within the States thus far?

Mr. Adams, we will start—maybe we will just go down the panel.

Mr. ADAMS. Well, the technology we used, based on the business model that we employ, is our own technology, so basically what we take from the State is the raw data, and we have to then process it.

Mr. UPTON. Did you—I think Kentucky was the main example that you cited.

Mr. ADAMS. Right.

Mr. UPTON. Did Kentucky come to you? Or did you make the sales pitch to them?

Mr. ADAMS. There are people in Kentucky that are aware of the capability that had been developed in Maine, and that is how the nexus was made, essentially.

Mr. UPTON. And what would be the—do you have a guess in terms of the savings? You talked quite a bit about you're able to provide a full spectrum, particularly going after overpayments to providers. Would you have some idea in terms of the States how much money you have been able to save the States? Can you calculate it?

Mr. ADAMS. We expect we can return to Kentucky in the near term—that means, measured in months, maybe 6, something like that—in the neighborhood of $25 million, which is a lot of money. But while it's a lot of money, we are absolutely convinced that it's the tip of the iceberg and that there's an enormous amount more there. From all we've seen, the 10 percent figure is not wrong.

Mr. UPTON. Mr. Viola.

Mr. VIOLA. Yes. We also do work on a service basis like Mr. Adams does, so we take the claims from the client and load it onto our systems and process the data.

In terms of getting involved with the individual States, we've been pretty aggressive in pursuing meetings with as many of them

as possible. And in the 17 I think I alluded to in my testimony they all have an enthusiastic embrace of the possibilities of what could occur but tend to be stymied somewhat by either the internal workings that slow down the process or some of the funding issues that would allow them to acquire and use the technology properly.

We tend to also focus, as I mentioned, on the organizational issues. Because to simply apply technology and not consider how the end results will be used in the organization and making sure you get cooperation from all the parties probably won't optimize the way that technology would be used. So we do spend some time trying to do that as well.

I should add that so far there have been very few takers on that part of our service.

Mr. UPTON. Now, the cluster that you showed on the TV screen, is that in practice now? I mean, was that just—I think it was Texas you talked about.

Mr. VIOLA. Actually, we didn't run into any States in particular in the presentation. Some—we've done work for Ohio, for New Jersey, some pilots for Georgia and a pilot for New York. And some—that's a conglomeration of some of the data from those particular pilots.

So the data—the processing is done now with that technology. As a consulting firm, we typically don't build our technology. We tend to look at who has good products out in the marketplace, and we try to work together. The IT tool that we showed that on is a pretty good example of link analysis, and this is a pretty good example of data mining.

We also used the HOPS Technology from HOPS in Miami. The reason we use that is it an extraordinary fast processor and, as many of us have described, there's a large number of claims and to do the processing effectively we need some good horsepower to do it.

Mr. UPTON. Mr. Glynn, you talked about nearly 5,000 suspects in Texas. I think that would have to be pretty good to open up the door for you.

Mr. GLYNN. We're finding it a very good selling point.

And to answer your first point on the level of activity, we are finding that in recent, you know, months literally—certainly in the last 12 months—there's a distinct increase in activity. There are numerous States that are currently looking at fraud and abuse. And obviously the evidence that we can show of success in Texas and in California helps to make the purchasing process easier and justify and support the opportunity.

Mr. UPTON. Ms. MacQuarrie, you admitted that the States are fairly outdated in terms of their equipment. Do you see a trend toward using what you all can provide? And what incentives are there for the States to upgrade their equipment?

Ms. MACQUARRIE. We have seen also a great increase in the interest in acquiring new technologies within the States. We have been out there and talked to many, many of them. And HCFA is trying to pave the way for States to acquire these new technologies.

However, there's a procurement process within each State where the actual SURS system that you heard a lot of testimony about today has traditionally, over the course of the past 20 years, been

a part of the greater Medicaid processing system called the MMIS. So most States buy their SURS systems from the fiscal agents, whose main line of business is paying claims, not finding fraud. And when we're out there dealing with the States we find that they are struggling in some cases to be able to buy these kinds of technologies from nonMedicaid claims systems vendors, which I don't think any of the panelists here today are. Our business is finding fraud, not paying claims.

So HCFA came out just about a year ago with some direction to States that it was all right to start to begin to break these two systems apart and acquire fraud systems from fraud-knowledgeable and expert companies, but it's been rather slow in coming and not all entities are comfortable in doing that yet. So that has been one obstacle, but we do find the interest has gotten, you know, much more acute and that States are moving forward and looking forward to these kinds of advanced technologies.

Mr. UPTON. Well, I appreciate that comment. And as we pursue some legislative remedies to try and strengthen the hand of HCFA, that will serve as a good reminder for us to try and provide that type of incentive for all States, particularly as we try to keep up with these thieves that we all want to catch.

Ms. MACQUARRIE. Yes. And I think in your opening remarks you made a comment about the great advancement in technology year to year. The PCs that we bought last year, you know, are out of date this year.

I think the same holds true in acquiring these kinds of systems in that HCFA requires that their SURS system be certified. The certification process alone takes more than 6 months. And by the time the systems that vendors like those who are sitting before you today are deploying new and advanced technologies, the certification process can slow down the States.

So although many States are moving in this direction, for every month and every year it takes for them to acquire these technologies it's that many more hundreds of thousands or millions or billions of dollars that are going, you know, to the fraudulent problem out there.

Mr. UPTON. Well, again, we appreciate your testimony. We look forward for additional input.

I'm told Mr. Bryant has no additional questions at this point. But we are all going to submit in likelihood questions from both sides and look forward to your responses back. And we will now excuse all of you. Thank you very much.

Ms. MACQUARRIE. Thank you.

[Whereupon, at 12:45 p.m., the subcommittee was adjourned.]

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